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Work Stress in the Forensic Psychiatric Facility: The Relationship between Coping Responses and Personal Need for Structure

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WORK STRESS IN THE FORENSIC PSYCHIATRIC FACILITY: THE RELATIONSHIP BETWEEN COPING RESPONSES AND PERSONAL NEED FOR STRUCTURE

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ABSTRACT

This research project was designed to investigate the relationship between coping response preferences and the personal need for structure of a sample (n = 84) of forensic psychiatric workers. The Coping Inventory For Stressful Situations (Endler & Parker, 1990a), the Personal Need for Structure Scale (Thompson, Naccarato, Parker & Moskowitz, 1993) and the Work Environment Form (Rivera, 1994) were administered to all participants. The results indicated that forensic psychiatric workers who endorsed items associated with a personal need for structure utilized a task-oriented coping response more frequently than emotion- and avoidance-oriented coping responses. A series of stepwise multiple regression analyses indicated that there was a relationship between a personal need for structure and task-oriented coping response preference that was not mediated by perceived social support, stress, or predictability. Given these findings, it was concluded that a personal need for structure may buffer the impact of daily stressors on job satisfaction of forensic psychiatric workers.

CHAPTER I

INTRODUCTION

Within the last 30 years much of the literature on coping has focused on defining, measuring, and making distinctions between two primary coping reactions (emotion and problem focused). After initially describing the coping process, as the reaction to perceived stress, investigators began to examine issues of coping strategies and efficacy. Coping responses which reduce negative affect and increase cognitive processes through active problem resolution were seen as effective stress coping strategies (Moos & Schaefer, 1993). That is, when individuals actively focus directly on the problem/stressor, stress reduction is noted (Endler, Parker, & Bagby, 1993).

Coping responses are made up of set schemas to be retrieved and implemented on demand. According to Neuberg and Newsom (1993), once a schema is selected to deal with specific stressors it tends to remain relatively constant. It is assumed that assessing factors contributing to the variation amongst individuals doing stressful work can provide a clearer understanding of coping strategy and individual differences. Other variables which might contribute to the effective resolution of stress have also been explored. Specifically, an individual's perceptions of

social support, stress, and predictability of events/behaviors. The individual's ability to interpret environmental cues (support, stress, predictability) has been found to offset stress (Billings & Moos, 1984; Burke, 1993; Fleischman, 1984; Holahan & Moos, 1987).

There appears to be considerable agreement in the literature that individual differences contribute to coping style and strategy preference. The selection of, and preference for, coping strategies plays a significant role in how people adapt to stressful situations. As such, the differences in adaptation to stressful situations and selection of a coping response can better assist in understanding how individuals process stressful events. In determining what characteristics an individual possesses and how they react to stress, an overall view of effectiveness in dealing with the particular situation and/or experience may be gained (Lazarus & Folkman, 1984).

One such individual characteristic is personal need for structure which has been described by Thompson, Naccarato, Parker & Moskowitz (1993) as an individual's desire for simple structure and aversion to lack of structure in their daily life. Neuberg and Newsom (1993) claim that "individual differences in the desire for simple structure may influence how people understand, experience, and interact with their world." This influence on how an

individual experiences his/her world is of special interest with respect to exploring coping response preferences. Personal need for structure allows for the organization and utilization of a coping response.

This study was designed in an effort to contribute to the coping structure and individual difference research literature. An individual coping with daily life or work stressors can vary in the degree to which he/she chooses to directly deal with the stressor. This research project was designed to focus on the relationship between an individual's personal need for structure and coping response selected. In extending the coping response research literature to include a relatively unexplored population of mental health care providers called forensic psychiatric workers, new information will be uncovered.

Forensic psychiatric workers are a combined group of psychiatric nurses and security mental health aides who receive specialized training while working with forensic psychiatric patients. Each has close daily contact with the forensic psychiatric patients on their unit. These psychiatric patients are deemed dangerously mentally ill and/or in need of monitoring by the court system. The forensic psychiatric workers' position within the facility is a stressful one. They have the most daily contact with these dangerous psychiatric patients, often having to

physically intervene. This, along with other factors, aids in making their job a particularly stressful one. A more fine-grained knowledge base focused on the relationship between an individual coping strategies and personal need for structure could contribute to the design of effective stress coping interventions for staff training.

The reasons for focusing this study on forensic psychiatric workers are both their importance in the treatment of psychiatric patients and the paucity of relevant current research addressing their perceptions. Since the stress experienced by these workers, coping responses, and their specialized perceptions have not been formally documented in the research literature, new knowledge in the area is desired. This new information, in turn, can then be utilized to design psychoeducational, training and employee selection programs to address the issue of coping reactions in this high stress field.

It was hypothesized that a forensic psychiatric worker relies on a preferential coping strategy based on their information integration. This coping preference is utilized because the individual has found it effective and, for various reasons, prefers it. As individuals deal with life events, they learn to address particular stressors with reactive behaviors and/or thoughts. These reactions or coping responses reflect individualized characteristics,

specifically personal need for structure, which can be influenced by many factors.

It is expected that researching the specific job and personality factors related to the coping response preferences of high-stress patient-care workers offers insight into their experiences. Since reactions to stress can be directly linked to the degree to which an individual experiences job satisfaction and burnout (Leiter, 1991), it would behoove administrators and workers alike to address the stress issue. In gaining this added insight, it is anticipated that the negative consequences resulting from stress (burnout, excessive missed or sick days, high turnover rates, constant training of new individuals or decreased work efficiency), which can all prove costly to an organization, can be avoided. In identifying those factors which can possibly lead to burnout, the effects on decreased level of staff performance, and patient treatment (Corrigan, 1993) can be accurately assessed and targeted for modification.

This research project utilized questionnaires that specifically probed coping response preferences, level of personal need for structure, perceptions of stress, social support, and predictability. A description of the more relevant research available on the selected variables follows in Chapter II. A description of the research

methodology, subject characteristics and instruments used is offered in Chapter III. The forensic psychiatric workers were surveyed while at work and their responses are summarized in Chapters IV and V.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Coping Responses

Stress and coping responses are defined in several ways in the literature (Lazarus, 1993). For the purposes of this study, stress was defined as the emotional response indicating "a particular relationship between the person and environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984). Stress results from the demands experienced by an individual. The individual's reaction to these demands or their coping response will be reflected in the behavior exhibited.

For the purposes of this research project, coping response was defined as "an individual's behavioral, affective, and cognitive attempts to mediate a perceived discrepancy between situational demands and personal capacity or competence" (Endler & Parker, 1993a). Stress and coping are generally seen as a "person-environment process that is cognitively mediated through an appraisal process (Lazarus, 1993)".

The individual determines both the degree of stress a particular event elicits and their own resources to deal with, or cope with, the event. Research indicates that coping response and how well an individual adapts to the specific stressors are related (Lazarus & Folkman, 1984).

Coping has been seen to have two major functions, "the regulation of distressing emotions (emotion-oriented coping) and doing something to change, for the better, the problem causing the distress (problem-oriented coping)" (Folkman & Lazarus, 1985, p. 152). In general, stress research has focused on various definitions of coping and has delineated models explaining two basic dimensions (active versus passive coping behaviors). Emotion-oriented (passive) and problem-oriented (active) coping behaviors focus on an individual's reaction towards integrating their desires into wanted results or consequences when faced with a stressful situation.

Cognitive theories of coping have been delineated by several contemporary researchers. Throughout the last 43 years, Lazarus (1966, 1975,1982, 1993) and his colleagues (Lazarus, Deese & Osler, 1952; Folkman, 1984; Lazarus & Folkman, 1984, 1987), have written about stress and coping responses. Lazarus, et al., theorize that the two basic coping preferences are mediated by the individualized appraisal of the existing stressor. This appraisal process

allows individuals to assess the stressor (i.e., primary appraisal) and to what degree they can adequately handle the stress (i.e., secondary appraisal). The process-oriented coping hypothesized distinguishes between problem-oriented and emotion-oriented coping responses during stressful situations.

Lazarus and his colleagues' theory holds that the difference between problem- and emotion-oriented individuals is that a problem-oriented individual seeks to make a change in the person-environment relationship in order to fix the problem itself. The emotion-oriented individual may, on the other hand, choose to directly regulate the level of emotional distress caused by the event by finding ways in which to calm down or relax. Both reactions allow an individual to modulate reported stress experience in the manner in which they feel most comfortable. Billings and Moos (1984), Carver, Scheier and Weintraub (1989), Carver and Scheier (1994), and Pearlin and Schooler (1978) also delineate various coping strategies. Although these theorists share the view that coping is an interactive process between the individual's perception of stress and their reaction to the stressor, they have not introduced the issue of stress avoidance reactions, per se. Therefore they developed instruments capable of supporting their

theoretical assumptions, to the preclusion of this avoidance-oriented coping.

Our knowledge of the relationships between personality characteristics and coping styles continues to grow (Moos & Schaefer, 1993). Although a review of research related to the orientation of copers is presented below, there has been a particularly scarce explanation offered for the more avoidant reactions (i.e., not doing anything directly influencing or addressing the stressful event). This is not true in the post-traumatic stress literature which highlight dissociate reactions to stress, but appears to be the case for the general coping literature.

The dichotomized attempts to explain the coping response preferences do not address this issue of avoidance-oriented coping. Stress and coping research does posit that individuals who experience stressful situations may tend to dissociate in an attempt to avoid the stress experience itself (Farrenkopf, 1992). They may choose to seek out social or asocial means with which to avoid their stress experience. Endler and Parker (1990a) more clearly utilize the possibility of avoidance-oriented coping response as a preference in dealing with stress. As such, they provide an explanation for coping responses which give more of a focus not only to active and passive responses, but to motive behind the response. Specifically, an individual can choose

to dissociate or avoid a situation through more than one method. Social diversion (partying, phone a friend, etc.,) or distraction through isolated tasks (go for a drive, watch T.V., read a book, sleep), both offer means through which avoidance of a stress can, at least temporarily, be attained.

This research included the three most popular, and relevant coping responses reflected in the current literature. For the purposes of this research, the coping responses explored were task-oriented, emotion-oriented, and avoidance-oriented in conjunction with Endler and Parker's (1990a) research on coping strategy.

Endler & Parker (1990a, b)

Endler and Parker (1990a, b) developed a "rational and empirically based" theory of coping that delineated three primary coping responses. These include task-oriented, emotion-oriented, and avoidance-oriented coping responses. Task-oriented coping is a reaction style that specifically deals with the stressful task at hand by addressing the problem directly. Emotion-oriented coping is more concerned with directly addressing the affect that the particular stressor elicited. Avoidance-oriented coping is focused on avoiding, altogether, that which has been deemed as a stressor. Avoidance-oriented coping is actually divided into distraction and social diversion activities wherein a

person strives to avoid the negative or stressful experience through either social or individual distraction efforts. As initial reactions to stress, coping reactions may play a role in the course of the stressor's role in the individual's life.

In examining the ways individual cope with stressful situations (task-, emotion-, and avoidance-oriented responses), Endler and Parker (1989, 1990a-c) added to the already large body of coping literature, a three variation model. Endler and Parker (1993a) offer an intraindividual, process-oriented approach which describes an individual's preferential coping strategy. These coping responses differ in behavior manifested during stressful events and effect on stress perceived by the individual.

Other stress and coping research studies have examined the issue of burnout (Ceslowitz, 1989; Cheek & Miller, 1983). These studies found that coping style buffers, to a certain degree, the effects of burnout. Of the three primary coping preferences explored, task-oriented (or problem-oriented) coping has been linked to decreased burnout symptoms. According to Leiter (1991), task-oriented coping is less related to burnout. Emotion- and avoidance-oriented coping, on the other hand, have been linked with a greater number of burnout symptoms. This finding supports the notion of a relationship between coping strategy and

burnout. It appears that the higher the symptoms of burnout, the greater the use of Escape-Avoidance coping responses (Burke, 1993).

Naisberg-Fennig, Fennig, Keinen & Elizur (1991) posited that individuals with discomfort in ambiguity and a preference towards structure are likely to cope with stress in a task-oriented manner. Task-oriented coping has been viewed by some as being a "more effective" way in which to deal with stress (Revicki & May, 1989; Parkes, 1986; and Burger, 1992).

When an individual, indicates a preference in coping response, there are factors which contribute to the utilization of a particular coping response. A brief description of task-, emotion-, and avoidance-oriented coping responses as interpreted by Endler and Parker and others is provided below.

Task-Oriented Coping

According to Endler and Parker (1990a), individuals who tend to use task-oriented coping are likely to organize behaviors towards dealing directly with the stressful situation or problems. In dealing with a stressful situation, an individual may choose to focus on the step-by-step procedures necessary to effectively address the problem, thereby reducing the degree of stress experienced. Individuals who report task-oriented coping preference claim

that "the main emphasis is on the task or planning, and on attempts to solve the problem" (Endler & Parker, 1990a).

Emotion-Oriented Coping

Those respondents who report emotion-oriented coping preferences tend to focus on the affect stimulated by the stress (i.e., their general feeling state). They attempt to work towards addressing the feelings generated by the experience, not necessarily focusing on solving the problem itself. An emotion-oriented coper may choose to focus the bulk of his/her energy in reducing the negative affect induced by the stressor by seeking more positive emotional experiences rather than resolving the problem. Emotional reactions or responses generated by a stressful situations can include self-blame for "being too emotional, get angry, become tense, self-preoccupation, and fantasizing" (Endler & Parker, 1990a).

Avoidance-Oriented Coping

Someone who reports avoidance-oriented coping preferences is involved in "activities and cognitive changes aimed at avoiding the stressful situation. This can occur via distracting oneself with other situations or tasks or via social diversion as a means of alleviating stress" (Endler & Parker, 1990a). A number of researchers have explored escape and avoidant coping associated with psychological symptoms (Aldwin & Revenson, 1987; and

Billings & Moos, 1984), and have reported that Escape or Avoidant coping is less effective than task-oriented responses in addressing medical illnesses and life problems. It appears that these individuals deal less effectively with medical illnesses and significant life events which require a more active and/or focused approach.

These three primary coping responses are selected (consciously or unconsciously) by the individual experiencing stress. This choice, per se, is influenced by the individual's personal characteristics and preferences (i.e., locus of control, self-efficacy, tolerance for ambiguity, etc.). An integral factor in the selection of a coping preference is the individual's cognitive preference and perceptions.

Perceptions and Coping Responses

Kobasa (1979) examined personality variables, ways of coping, and social support. She developed a construct termed "hardiness" to describe personality factors that buffered or moderated an individual's experience of stress. Persons high in hardiness (i.e., commitment, challenge) suffered from fewer stress symptoms (Kobasa, 1979). This research also suggests that the use of emotion-oriented coping is positively correlated with negative stress symptoms. People high in hardiness tended to use problem- or task-oriented coping responses and they fared better in

stressful situations (Ceslowitz, 1989; Corrigan, 1993, and Thornton, 1992). Individuals with high levels of self-efficacy (Fleischman, 1984), internal locus of control (Parkes, 1986), self-confidence (Holahan & Moos, 1987), optimism, control and self-esteem (Carver, et al, 1989) are more likely to rely on coping behaviors that approach problems. That is to say, they direct more action towards the problem in an attempt to deal with stressful situations.

This possible link to personality provides some support for the notion that characterological disposition may influence coping responses. Moos and Schaefer(1993) documented gender differences in coping styles; women have a tendency to use avoidance coping processes more frequently than men. McCrae (1989), and Folkman, Lazarus, Pimley, & Novacek (1987) found that age may also be related to coping style. They found that older adults are more likely to rely on cognitive approaches to coping more frequently and are less likely to seek out social support.

An individual's perceptions of social support (Graf, 1986; Singh, 1990) and predictability of events (Linaker & Busch-Iversen, 1995) has been found to influence occupational stress and coping reactions. Specifically, it has been found that an increase in perceived social support is correlated with a decrease in perceived occupational stress (Graf, 1986) and adequate stress adjustment (Singh,

1990). The research suggests that the perception of social support of individuals in high stress professions influences their perceptions of stress. Specifically those who perceive adequate social support (like the police officers and nurses used in many of the studies cited), perceive less overall stress. This finding supports the notion that there is a relationship between personal perceptions and stress adaptation. Additional research has indicated that the actual social support received may be less important than the support which is perceived by the individual (Wethington & Kessler, 1986).

These combined findings were used to design the dissertation research study at hand. Specifically, an individual's perception of stress, social support, and predictability were seen as factors contributing to an individual's overall coping response, and were added as independent variables. The next section more specifically discusses work related factors which make certain positions particularly stressful, examining the issue of stressful work and contributing factors.

Stressful Work

Stressful work is work which includes tasks which may pose risk or threat to the individual engaged in the job. Stressful work also includes tasks which challenge the

individual's emotional and cognitive resources on a daily basis.

Individuals who work in the patient care field choose to help those in need, and stress is an integral part of that work. Psychological or medical, and protective care workers (police and correctional officers) are all in professions with a great degree of human contact. Working directly with people, especially difficult individuals, does cause considerable stress (Revicki & May, 1989).

There has been recent work to suggest that the manner in which an individual deals with stress is related to not only job satisfaction, but the quality of patient care and/or treatment (Ceslowitz, 1989; Gray, & Diers, 1992; Kaplan, 1987; Keller, 1990; Naisberg-Fennig, et al., 1991; Neale, 1991; Schaefer & Moos, 1991; Schniedermayer & Tesch, 1992; and Thornton, 1993). In understanding a worker's perceptions and coping preference their experiences at work or home can be better appreciated. This better appreciation of their work experience can lead to administrative changes which, in turn, can have a positive impact on their work.

An individual experiences stress at various levels, both internally and externally. For the purposes of this study, stressors are viewed as related to both work and personal issues. Work related issues may include low wages, lack of administrative support, patient characteristics,

peer relationships, and lack of input towards policy changes. They may also include, but are not limited to inadequate supervision, non-participation in decision making processes, staff shortages, poor training, coworker/supervisor problems, and job/role ambiguity. Personal factors contributing to the experience of stress include family problems, medical problems, financial difficulties, lack of status, commuting difficulties, social isolation, and significant personal losses. Although not all inclusive, these issues/factors appear most frequently discussed in the literature as stressors in the workplace (Cheek & Miller, 1981, 1982a, b).

Mental health staff who work with patients face additional stressors. Patient characteristics which increase patient care stress includes the patient's history of violence or dangerousness, precaution levels placed on patients (i.e., escape, suicide, assault risks), overcrowdedness of units and/or facilities, and predictability of behavior.

For the most part, the factors listed above have been confirmed as stressors in the workplace for nurses (Kaplan, 1987), physicians (Orman, 1989), psychiatrists (Naisberg-Fennig, et al., 1991), psychologists (Sullivan, 1989), social workers (Egan, 1993), therapists (Farrenkopf, 1992), and mental health aides. No research effort has

specifically explored forensic psychiatric workers and their stress experience. Although stress cannot totally be avoided when working with difficult populations, it must be dealt with effectively, or negative effects may ensue. The negative effects mentioned in the literature include depressed or irritable mood, possible medical conditions, substance abuse problems, and possible poor patient treatment (Ceslowitz, 1989).

At first it may appear a bit bleak for the individual who chooses to pursue a patient care profession. However, there are certain steps that employees and employers alike can take to decrease stress in the workplace. Although there is no universal protocol for absolute stress reduction, the literature indicates that communication of experiences coupled with peer and/or familial support may contribute to minimizing stress (Schniedermayer & Tesch, 1992). Employee Assistance Programs, psychoeducational seminars, and supervisor training can also aid in the systematic identification and treatment of workplace stress by detailing common or specific stressors and offering suggestions for dealing with them.

In the area of mental health, studies have focused on how stress factors in the work environment affect psychiatric center staff burnout (Sullivan, 1989; Zautra, Reynolds, & Eblen, 1987). These studies indicate that

negative perceptions of the job, lack of administrative support, and poor peer relations contribute to stress and burnout.

Coping strategies, work and personal stressors, along with the perception of inadequate social support and high levels of stress, have also been clearly found to influence job satisfaction and burnout (Naisberg-Fennig, et al., 1991). This finding appears to be particularly relevant to the study of forensic psychiatric workers who work in highly demanding, stress producing jobs.

Yet, the coping response preference and the work stress experienced by the forensic psychiatric workers has not been systematically investigated. Correctional, psychiatric, and medical populations have received more of the attention (Brodsky, 1982; Egan, 1993; and, Haller & Deluty, 1988). The stress reactions of medical professionals has been researched extensively throughout the last 20 years. Schniedermayer & Tesch (1992) explored stress among primary care physicians, Keller (1990) studied stress among emergency nurses, and Neale (1991) studied stress among emergency medical technicians. All reported that stress is inevitable, but manageable.

Stressors for medical workers included problems with intra-facility communication and relationships, low status, administrative aloofness, problems with family and/or social

life, perceived understaffing, poor morale, perceived inappropriate patient treatment, and perceived lack of administrative input. Stressors also included the worsening of the medical condition and/or dying of a patient, the litigious patient, and the overly demanding patient. Not only does the patient have an effect on the stress level of the staff, but the staff's reactions to patients may also effect patient stress levels. Nursing staff stressors related to medically ill patient care have been reported to have measurable effects on patient's care and/or treatment factors (Kaplan, 1987). Potential negative effects of a stressed staff suggests areas where patient care can be compromised (i.e., decrease in patient support, irritability towards patients, etc.,).

Additionally, family resources, work resources, and social supports are all seen as factors which contribute to levels of stress and coping styles (Holahan & Moos, 1987a). The relative importance of social support that many individuals express, provides us with a data set related to what variables influence coping responses to stress in the workplace. The forensic psychiatric worker may experience additional strain if they feel unsupported by their family, peers, supervisors and/or the administration. This lack of support during particularly stressful experiences can lead

to considerable cynicism (Hansen, 1981), which in turn, may adversely effect job satisfaction.

Another group of medical workers, the psychiatric workers (i.e., psychologists, psychiatrists, psychiatric nurses, social workers and mental health aides) who work with the chronically mentally ill have been examined by various researchers.

Gray and Diers (1992) reported a relationship between the emotional stress experienced by the caregivers and the behaviors of the patients in their care. Their finding can be used to support the notion that there are passive effects of caregiver stress on patients. Specifically, a greater level of cynicism and a decrease in staff moral were noted with increases of work related stress in these settings.

It appears that a patient's unpredictable behavior coupled with a history of violent behavior may make working with such a patient particularly stressful. The recidivist, uncooperative, and hostile patient are all particularly difficult to manage. Working with this patient population may shift the worker's opinion, from neutral to negative (Farrenkopf, 1992). This, in turn, may affect patient treatment.

Correctional workers (Brodsky, 1982 and Cheek & Miller, 1981, 1982a, b, 1983) and police officers (Burke, 1993 and Colegrove, 1983) are also in uniquely stressful jobs and

often burnout. Correctional officers and burnout stress have been the focus of much study in the past two decades. Stress is a widely accepted, common feature of working in a correctional facility (Cheek & Miller, 1981, 1982a, b, 1983; and Colegrove, 1983). It contributes to the phenomena of burnout. Specifically stressful are the noise levels, daily violence among in-mates, the potential for physical and verbal assault, and work with the "Nut-cases" (Breen, 1987). This coupled with possible friction in peer, supervisory, and administrative relationships may also contribute to perceived stress (Breen, 1987). Adding possible family problems may, in-turn, contribute to the high incidence of substance abuse, marital and/or family discord, and affective problems of this population (Hansen, 1981; and Cheek & Miller, 1983).

It is clear that the workers in medical, psychiatric, and correctional settings are similarly affected by stress. The need for control and structure has already been linked to correctional officers (Colegrove, 1983). Colegrove's study (1983) found that correctional officers have a great deal of ward management responsibility to follow administrative policy. With this responsibility, their work shares similar features to that of the forensic psychiatric worker since they both seek to confine, care for, and monitor individual's with restricted freedom of movement.

These features offer them an experience or general sense of control over others which may also play a role in coping response preference. When an individual works in a rigid, paramilitary organization, there are certain personality features which either existed before the job or formed during the job that make the individual uniquely equipped to do the work.

In assessing factors which contribute to the forensic psychiatric workers' coping response, the perception of stress, predictability and social support were explored. The factors characterized as an individual's personal perception of life experiences were found to be most relevant. These factors included an individual's internal experiences (family, career, financial, medical status) and the relationship with his/her peers and/or family members. This next section seeks to discuss the difficult role of the forensic psychiatric worker in the facility.

Forensic Psychiatric Workers

For the purposes of this study, forensic psychiatric workers were defined as the nurses and security mental health aides who work within a forensic psychiatric facility. The role of the nurse within this milieu is to administer medications, monitor a patient's daily psychiatric and medical health, and act as a liaison to the

psychiatrist, psychologist, social worker and/or physician involved with the treatment of the patient.

Although the security mental health aide is not directly responsible for the medication management of the patient, they are responsible for observing and managing patient behaviors. They escort patients to the various therapeutic activities and constantly monitor patient behaviors. The goal of the security mental health aide is to assure that each patient adheres to the rules and structure within the unit, without acting-out against self, peer, or staff. This is a difficult task. Generally, it is because of the patient's acting-out behaviors (antisocial or otherwise), that they have been court-mandated into the forensic psychiatric facility. Mental health aides and nurses have similar roles and spend the most number of hours in close patient contact.

Being at risk of a patient's aggression is likely to introduce increased levels of stress into the job of nurses and security mental health aides who decide to work within the forensic psychiatric setting. With this risk comes the increased importance of utilizing an effective coping responses, so as to diminish the potential negative effects such stressors can induce.

Patients in forensic psychiatric facilities can generally appear unpredictable and difficult to manage.

These psychiatric patients are considered to be dangerous by our legal system, either because they have acted-out, or are assessed as being likely to act in a violent manner. They are often physically aggressive and can be assaultive (Linaker & Busch-Iversen, 1995). The perceived predictability of the threat of physical harm in working with these patients will likely influence the level of stress experienced by forensic psychiatric workers (Linaker & Busch-Iversen, 1995).

A relevant factor in researching this sub-population of mental health professionals is their integral role in the treatment and rehabilitation of the forensic psychiatric patient. Forensic psychiatric workers were chosen for this study because of the paucity of coping research available on the population. Forensic psychiatric workers are the front-line staff members who have a great deal of daily contact with both the patients and facility administrators. Most would probably agree with the statement that balancing the needs of patients for a therapeutic milieu with the demands inherent in implementing a behavioral management regimen in a forensic psychiatric facility is a difficult task. The demands the administration places on the forensic psychiatric worker and their interpersonal relationships with patients, peers, and supervisors may increase the complexity of their role within the forensic psychiatric

facility. The forensic patient's acting-out, constant need for behavior monitoring due to unpredictable behavior, various levels of delusional thinking, and need for sporadic physical restraint makes working with this population particularly challenging.

Documenting the forensic psychiatric worker's experiences will contribute to the training of individuals to deal with this population. Given the increase in reported violent crimes perpetrated by the mentally ill (Hodgins, 1992) and the high turnover rate of forensic psychiatric workers, understanding stressors which can impact their work could prove helpful for both the worker and the patient (Linaker & Busch-Iversen, 1995).

Adding to the already high levels of work stress, there appears to be a rise in the frequency of violent behavior by psychiatric patients (Hodgins, 1992). Several researchers are striving to identify behaviors and situations which precede patient violence so as to better predict their aggression and address the negative effects on staff (Haller & Deluty, 1988). Recently, five factors were found by Linaker and Busch-Iversen (1995) to be most predictive of imminent violence in psychiatric patients at a maximum security facility. These factors included "psychosis, negative signs," "psychosis, positive signs," "threatening behavior," "irritable confusion," and "quiet opposition."

They found that psychiatric patients about to attack communicated their intention "more obviously" than non-psychiatric "patients about to perform violence." This finding is particularly interesting because it supports the notion that observers can predict patient acting-out behaviors if they are aware of those specific behaviors that usually precede the incident. Training programs could be developed to educate and inform workers as to the observable behaviors which generally may precede violent patient behavior. With increasing predictability, it is hoped there will be a decrease of work related stress.

Previously, this literature had pointed to random, unpredictable behaviors causing stress to the care-givers. Now we see that these behaviors are somewhat predictable through careful and informed observations. However, it remains unknown as to what effect the ability of forensic psychiatric workers perception of being able to predict the patient's acting-out buffers against stress. For the purposes of this study, exploration of the workers' perceptions and preferences will be examined in the forensic psychiatric setting.

The forensic psychiatric worker not only must be aware of patient behavior but must also react quickly to redirect or set limits on inappropriate behavior (i.e., fighting, sexual acting-out with peers, etc.). Speeded integration of

the feedback received from particular stressful situations was recently suggested to be related to an individual's personal need for structure (Kaplan, Wanshula, & Zanna, 1991). Since a forensic psychiatric worker must deal with erratic patient behavior, they must utilize cognitive strategies in expeditious ways. In using a set reaction or structure for dealing with patients, they can deal quickly with patient behaviors. In other words, when an individual goes through a lengthy decision making process the first time a particular stressful situation presents itself, it would prove time consuming if they repeated that process on each occurrence of the situation. Instead of re-processing the decision to deal with each occurrence of a particular behavior, it is believed more efficient to rely on preset notions (Kaplan, Wanshula, & Zanna, 1991).

The way in which the individual chooses to behave has been previously learned and relied upon in specific situations. Specifically, the forensic psychiatric worker's role within the facility is to constantly shape and monitor patient behaviors. They are responsible for the implementation of treatment team decisions as well as the placement of restrictions and the setting of limits on inappropriate behaviors. This is often seen by the patients as negative contact and may make the forensic psychiatric worker particularly disliked by patients. Patients may act-

out against the forensic psychiatric worker at various points during the day as a result of this negative perception. The patient's acting out can take the form of physical assaults and threats, false accusations of abuse, verbal aggression, and other like retaliatory behaviors. These assaults can occur with or without warning, making the forensic psychiatric worker's instant judgment integral to his/her safety.

Coping Response Research with Forensic Psychiatric Workers

There is no research on the topic of coping response and personal need for structure of forensic psychiatric workers. For the most part, research in the forensic psychiatric facilities has focused on patient characteristics and dangerousness. Anecdotal reports of the job stress experienced by forensic psychiatric workers do exist however. Stories circulated within the facility are about attacks by patients or injuries sustained while restraining patients. These reports have only led to further research on patient "dangerousness" variables, but rarely on the stress induced by such incidence on the caregivers.

Periodically, institutional researchers have administered informal, unpublished "Staff Satisfaction" questionnaires to assess work related concerns and/or issues of employees (i.e., hours worked, policy issues, and problem

identification). Typically they do not assess job stress per se. Many administrators report that these surveys tend to result in low response rates and minimal feedback from staff. The forensic psychiatric workers appear to fear that identifiable information will be traced back to them, thus having a negative impact on their job.

As discussed previously, these combined stresses place the forensic psychiatric worker at risk for personal stress related problems (i.e., medical problems, alcohol or drug abuse, marital and/or family problems, overall life dissatisfaction and depression) frequently seen in their correctional, psychiatric, and medical counterparts.

One could argue that if mentally ill offenders have been deemed unfit for society, for whatever reason (or amount of time), then society is responsible to provide them with skilled, humane care, and treatment so as not to worsen their psychiatric condition. In previous research on stressful work environments high turnover rates are noted. These rates, possibly due to unaddressed stressors, have resulted in the inadequate training of workers to deal with patient behaviors. This high turnover rate can also conceivably continue to contribute to compromising patient care in the future. If help providers are experiencing stress reactions, the patient's treatment will be affected. Research is needed to document the connection between coping

and personality variables for this population of caregivers. The following section offers an overview of personal need for structure as a variable used in this study in hopes of better understanding forensic psychiatric workers coping responses.

Personal Need For Structure

Personal need for structure was first defined by Thompson, et al. (1993) as "a means by which individuals organize and make sense of their experiences." For Thompson, a personal need for structure was considered to be a personality feature related to an individual's need to have an organized environment. It has been operationalized as cognitive reduction and a preferential cognitive structuring style. This construct is viewed as delineating an individual's expressed need for simple structure in daily life by tapping into the knowledge acquisition process (hypotheses generation and validation), comfort level with structure, predictability, tolerance of uncertainty, and flexibility.

The personal need for structure construct is unique in that it specifically describes an individual's expressed interest in simple structure, and discomfort with lack of structure inherent in some complex situations. The research suggests that when an individual is under a time pressure, they will react to a situation with preset notions and draw

inferences via these previously organized structures. This characterizes personal need for structure as the "desire for guided knowledge on a topic and is reflected in decisiveness, judgmental confidence and discomfort with lack of clarity" (Thompson, et al., 1993).

An individual with high personal need for structure tends to prefer structure and is more decisive than someone with minimal personal need for structure. But they also tend to be somewhat rigid, inflexible, and less effective in creative situations. "This style may be less useful in situations which require the rapid review and reconsideration of beliefs in light of new evidence" (Thompson, et al., 1993). Neuberg and Newsom (1993) found that individuals with a personal need for structure were more likely to apply previously acquired social categories to new situations. Individuals with personal need for structure also tend to use simple, less complex ways of organizing social information.

Most of the research related to personal need for structure comes from lay epistemics, beginning less than 10 years ago. Lay epistemics (Kruglanski & Freund, 1983; Kruglanski, 1989), is the process by which cognitive hypotheses are generated, tested, and implemented. The individual generates a hypothesis about a specific event and then acts based on the hypothesis. As such, personal need

for structure is less focused on the stressful event and more on the individual's cognitive structuring style, and/or preference. The style, per se, determines how the individual copes with certain situations.

Personal need for structure is an independent, individual difference variable that may help to identify processing differences in social categorization. The personal need for structure influences how a person perceives and categorizes his experiences (Moskowitz, 1993). Freund, Kruglanski, & Schipitzajzen (1985) found that it also influences the manner in which an individual makes decisions. Naccarato (1988) found that individuals with a high personal need for structure apply stereotypes more readily and extensively. This finding indicates that these individuals have a tendency to utilize simple strategies. Moskowitz (1993) indicates that personal need for structure moderates priming effects, that is, an individual with a personal need for structure tend to make "top of head decisions" or "let social attitudes guide their judgment."

Personal need for structure is believed to be related to coping, in that the higher the personal need for structure, the more decisive an individual will be during stressful periods, and more likely to rely on a task-oriented coping strategies. It has been posited that perceived predictability is related to personal need for

structure because of the 'structured decisiveness' suggested by the construct. Therefore, the task-oriented individual is likely to exhibit greater personal need for structure because of the cognitive processing style which is structured in nature. These individuals will tend "to freeze on the first available explanation, and are unlikely to search for further alternative judgments or explanations (Thompson, et al., 1993)." They use problem or task focused strategies in addressing the stressors, and are thereby generally considered to be more efficient copers.

Research provides data in support of a relationship between locus of control (or perceived control) and stress coping efficacy (Parkes, 1986), but the personal need for structure construct has not been systematically explored. Personal need for structure shares features with other personal need constructs (i.e., need for control, rigid thinking, and authoritarian beliefs) but continues to remain distinct.

It would follow that personal need for structure offers the individual a pre-set repertoire of reactions to cope with inappropriate patient behaviors. In turn, workers may perceive the event as predictable. This perception of predictability may give the person a greater sense of perceived structure which can affect coping response preferences.

In this research it was posited that individuals expressing a need for structure have already simplified generalizations of previous experiences which in turn helps them stereotype patient behaviors as dangerous but predictable. This thereby increases their expressed level of confidence in the prediction of violent patient behaviors. An increased amount of experience with this patient population can increase the reported caregiver comfort thus buffering the experience of stress. The lack of environmental structure for the individuals who use task-oriented coping styles, may play a roll in the level of perceived stress.

The Present Study

This study was designed to examine the degree to which personal need for structure is linked to level of perceived stress, social support, perceived predictability, and coping responses. A number of stress factors (i.e., job related, patient related, and family and/or social related stressors), social supports (to what degree does the respondent report feeling supported by family, friends, peers, supervisors, and administration) and predictability were systematically explored.

Research exists indicating that individuals tend to have certain stress coping preferences which they utilize during stressful situations (Endler & Parker, 1990a-c, 1993;

and, Fleischman, 1984; Miller, Brody & Summerton, 1988). Given the review of the literature, it was posited that a personal need for structure would be related to perceived stress, social support, predictability, and type of coping style. Delineating the role of personal need for structure in coping response selection hopefully will offer insight into possible factors contributing to the stress experience of forensic psychiatric worker.

For this study, the perception of social support, stress and predictability were also added in and effort to more clearly identify links among coping predictors. In reviewing the coping literature, it was evident that perceptions of stress, social support, and predictability are related to coping behavior. Since these perceptions can play a role in coping style, they were added as variables. The research questions follow:

Research Questions

1. What is the relationship between personal need for structure and perceived predictability?
2. What is the relationship between personal need for structure and perceived stress?
3. What is the relationship between personal need for structure and perceived social support?
4. What is the relationship between personal need for structure and task-oriented coping responses?

5. What is the relationship between personal need for structure and avoidance-oriented coping responses?

6. What is the relationship between personal need for structure and emotion-oriented coping responses?

7. What are the best predictors of task-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support)?

8. What are the best predictors of avoidance-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support)?

9. What are the best predictors of emotion-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support)?

Hypotheses

The following hypotheses, which are stated in the null, were tested:

1. There is no relationship between personal need for structure and perceived predictability.

2. There is no relationship between personal need for structure and perceived stress.

3. There is no relationship between personal need for structure and perceived social support.

4. There is no relationship between personal need for structure and task-oriented coping responses.

5. There is no relationship between personal need for structure and avoidance-oriented coping responses.

6. There is no relationship between personal need for structure and emotion-oriented coping responses.

7. There are no clear predictors of task-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support).

8. There are no clear predictors of avoidance-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support).

9. There are no clear predictors of emotion-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support).

The next chapter describes the methodology used for the study.

CHAPTER III

METHOD

Introduction

First of all, it should be noted that approval for this research project was received from the Institutional Review Boards at Loyola University Chicago (see appendix A), Kirby Forensic Psychiatric Center (see appendix B) and the New York State Office of Mental Health's Department of Forensic Services (see appendix C). The authors of the Personal Need for Structure Scale (Thompson, Naccarato, and Parker) granted the researcher permission to utilize the instrument for the study (see appendix D). Permission to use six items from the Coping Inventory for Stressful Situations was granted by Multi-Health Systems (see appendix E). The facility director and the senior supervisors of the facility also offered their support to this project.

Subjects

This participant sample included forensic mental health aides (n = 96) and forensic psychiatric nurses (n = 25), all of whom were told of the research effort and invited to participate. There were flyers posted throughout the facility reminding workers of the data collection dates (see appendix F). From a potential sample of 121, 96 completed

surveys (representing a return rate of 79%) were collected. Eighty-four of the 96 surveys were complete (representing a rate of 88%) and appeared free of response set patterns. This sample of 84 forensic psychiatric workers was self-selected from a population of forensic psychiatric workers at a maximum-security, forensic psychiatric facility in a large metropolitan area. The facility collaborated on this project by allowing the researcher access to this population and use of their resources (such as bulletin boards, office space, etc.). In return, they received feedback on the general research effort, without compromising the confidentiality and/or anonymity assured to the participants. The feedback included the number of respondents, the general stress experienced, and the degree to which they perceived the facility administration as supportive. At this particular facility, there were three shifts daily, six different units with a capacity for 150-patients. As a state-run forensic psychiatric facility patients are remanded from a catchment area of lower New York State. Of the six units, only one was for female patients. At the time of the study there were approximately 147 patients (119 male, 28 female) at the facility.

Forensic workers are trained in dealing with psychotic violent patients. They learn restraining methods, behavior modification techniques, diagnostic observation skills, expected patient behavior patterns, and how to de-escalate

potentially violent situations. All patients who were able to participate in various activities (arts and crafts, music appreciation, workshops, library services, etc.) rotated from one floor in the facility to another. The patients who left the primary unit and mingled with the other patients in the facility required considerable supervision. While involved in activities and programs, the forensic psychiatric workers were responsible for ensuring their safety and compliance with unit procedures and policies. The forensic workers work as a carefully coordinated team.

Instruments

This study utilized a number of self-reported measures to examine how the forensic psychiatric workers' personal need for structure, coping responses (task-, emotion-, avoidance-oriented) and perceptions (stress, social support, and predictability) were related. Derogatis (1993) remarked that self-reported measures of stress have several attractive features. The "economy of professional effort," along with the fact that they are "highly amenable to actuarial methods of scoring," "cost-efficient," and "brief" make them a particularly enticing choice to the researcher (Derogatis, 1993). The major drawback is that self-report inventories rely on the subject answering honestly with little influence of the social desirability of responses. Subjects were assured of anonymity and confidentiality in an

effort to increase the number of respondents and the reliability of their responses.

The complete set of survey instruments was administered after a notice of informed consent was signed by participants. This notice alerted respondents to the anonymous, confidential, and voluntary nature of the research project (see appendix G). A statement regarding the focus and procedure of the study was given to the sample (see appendix H). An eighth-grade reading level and the ability to use a pen/pencil were required to complete the survey instrument.

The measures included the Coping Inventory For Stressful Situations (Endler & Parker, 1990a; see appendix I), Personal Need for Structure Scale (Thompson, et al, 1993; see appendix J), and the Work Environment Form (Rivera, 1994; see appendix K). Reliability and validity information is included.

Coping Inventory For Stressful Situations.

The Coping Inventory For Stressful Situations was developed by Endler & Parker (1990a-c, 1992, 1993a-b; see appendix I). It was designed to assess three basic coping styles or orientations: task, emotion, and avoidance (distraction and social diversion). Endler and Parker (1990a-c, 1993) posited that there are three primary ways people react to stress. People can choose to focus on the problem itself, the emotions stirred by the event, or avoid

the distressful experience altogether. This view of coping responses is based on the premise that each individual has a distinct preferential coping style that is utilized when stress is perceived.

Endler and Parker (1990a-c, 1993) view coping as a trait-characteristic. These coping categories or preferences distinguish the ways in which people react to stressful experiences. For example, a 45 year-old man experiences a symptom of a significant medical illness and visits his physician. He is told that he has a serious, unexpected illness for which he will need extensive treatment. He may respond to the stress induced in different ways. He may be anxious but choose to focus on getting information about the illness so as to be well informed and aware of various treatments or therapies. This man would be said to be task-oriented with respect to his approach to dealing with the stressful experience.

Another man, when faced with the same diagnosis, may seek out the comfort of loved ones for soothing and support in hopes of decreasing the anxiety, apprehension or fear resulting from the stress event (diagnosis). This individual would be focused on addressing the emotions involved in the experience (e.g., calming himself). This emotion-oriented approach could help to decrease the overall anxiety experienced by this type of individual.

Yet another man may choose to avoid the stressful experience altogether, possibly by not going to the physician for the necessary medical attention or disregarding a negative diagnosis. This avoidance-oriented response may include seeking out social diversions or task distractions to keep himself busy, and his mind off the symptoms and/or problems at hand.

On the Coping Inventory For Stressful Situations Scale (Endler & Parker, 1990a), participants are asked to rate forty-eight coping activities on a five point scale. These items are organized into three main sections (consisting of 16 items each). Each section is designed to assess the degree to which an individual engages in task-oriented, emotion-oriented, or avoidance-oriented coping behaviors to deal with stressful situations. For each of the 16-item scales, a score from 16 to 80 is possible, with 16 indicating the lowest and 80 indicating the highest item endorsement.[1] On the 8-item task distraction subscale, the range is from 8 to 40. The 5-item social diversion subscale has a range from 5 to 25. The percentile will indicate how much "more" of a certain coping strategy the individual uses than his or her peers.

In interpreting the responses to the Coping Inventory For Stressful Situations scale (Endler & Parker, 1990a),

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[1]To make interpretation easier during analyses, the items on each scale were summed and then divided by the total number of items to convert the scale back into it's original units of measurement.

linear T-scores greater than 55 were considered as significant indicators of coping orientation preference. Each linear T-score from 50-55 was interpreted after taking each of the other scales into account. Scales that were previously developed from various coping theories had marginal internal reliability ranging from .41 to .66, but the Coping Inventory For Stressful Situations Scale (Endler & Parker, 1990a) appears to be a rigorous instrument designed to test and support the current theory. Others have attempted to develop similar instruments to study stress (Holahan & Moos, 1993; Lazarus & Folkman, 1987). However, Endler and Parker (1990a) have developed the only instrument designed to reflect a balance among possible coping approaches.

Historically, coping research has generated several viable theories, but few robust measures exist to assess preferential stress coping strategies. The Lazarus group (Folkman and Lazarus, 1984) produced the Ways of Coping Questionnaire, an episodic measure that was designed to assess behavioral and cognitive coping strategies. Although it has many limitations, it continues to be one of the most widely used instruments in the coping literature. Given the issue of structure and control in the study, it was important to have instruments which have been previously used in various samples and instruments which are sensitive to the research questions at hand.

The Coping Inventory For Stressful Situations (Endler & Parker, 1990a) has also been used in many research studies to explore coping responses in diverse populations (adolescents, undergraduates, adults, psychiatric patients, medical patients, job applicants, Mexican undergraduates, and prisoners). Overall, it appears to be psychometrically sound and is clearly interpretable. The reliability coefficients for the task- (.90, male; .90, female), emotion- (.87 male; .88 female) and avoidance-oriented (.85 male; .83 female) coping scales were strong (Endler & Parker, 1993). This instrument has also been demonstrated to hold an adequate 6-week Test-Retest reliability for the task- (.73 male; .72 female), emotion- (.68 male; .71 female) and avoidance-oriented (.55 male; .60 female) coping scales (Endler & Parker, 1993). It should be noted that due to copyright issues, the publisher, Multi-Health Systems, only allowed reproduction of six items on the scale (see appendix E).

The Coping Inventory For Stressful Situations (Endler & Parker, 1990a) was compared to other inventories designed to measure coping strategies. In particular, the Coping Strategy Indicator (Amirkhan, 1990) and the Defense Style Questionnaire (Bond, Gardner, Christian, and Sigel, 1983) were found to be a significantly related. Also, a moderate positive correlations was found among the Coping Inventory For Stressful Situations (Endler & Parker, 1990a) the

emotion and distraction scales, and the Coping Strategy Indicator's avoidance scales (Amirkhan, 1990). The Coping Inventory For Stressful Situations (Endler & Parker, 1990a) was also found to be negatively related to psychopathology scales. Furthermore, research using the Basic Personality Inventory (Jackson, 1989) suggests a link between emotion-oriented coping and depression, anxiety, and poor recovery from medical illness.

The Coping Inventory For Stressful Situations' (Endler & Parker, 1990a) task-oriented scale was found to be positively correlated with the problem solving scale of the Coping Strategy Inventory (Amirkhan, 1990). The Coping Inventory For Stressful Situations (Endler & Parker, 1990a) distraction scale was found to be similar to the Coping Strategy Indicator's (Amirkhan, 1990) social support seeking scale for men. The convergence and divergence with related coping inventories in expectable ways (Endler & Parker, 1993a; Endler & Butcher, 1993). Additionally, this instrument holds moderate criterion related validity (Moos & Schaefer, 1993).

Personal Need for Structure Scale

The Personal Need for Structure Scale (Thompson, et al., 1993; see appendix J), is a measure used to assess an individual's desire for clarity, certainty and an aversion to ambiguity. This is the only scale found to be a reliable measure of the construct. It is a simple, 12-item measure

that assesses the degree to which an individual desires structure, and expresses discomfort to a lack of structure. Respondents are asked to indicate, on a scale from 1 to 6 (1 being strongly disagree, through 6 strongly agree), their feelings on each statement.[2]

Instruments developed with a similar construct as the focus have been assessed by Neuberg and Newsom (1993). For example, the Authoritarian scale (Adorno, Frenkel-Brunswick, Levinson, & Sanford, 1950, in Neuberg & Newsom, 1993) was found to be moderately correlated with personal need for structure ($\underline{r}(56) = .25$, $\underline{p} < .05$). A compilation of five studies by Neuberg and Newsom (1993) offered detailed description of the personal need for structure construct. It was found to be negatively correlated with attributional complexity ($\underline{r}(460) = -.10$, $\underline{p} < .02$) and need for cognition ($\underline{r}(303) = -.29$, $\underline{p} < .001$) scales (Neuberg & Newsom, 1993). Dogmatism, intolerance for ambiguity and uncertainty orientation, may also seem superficially convergent with Personal Need For Structure Scale (Thompson, et al., 1993) but according to Neuberg & Newsom (1993), they are distinct. This research indicates that personal need for structure is much better suited for the task of operationalizing, in a "reliable and direct manner" the construct of interest in structure, whereas the others are not.

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[2]Same note.

Neuberg & Newsom (1993) recently correlated personal need for structure with four somewhat related measures that assess personality characteristics: Authoritarianism, Rigidity, Depression, and Self-Consciousness. Although each measure was found to share common features with personal need for structure, they each had distinct differences. The Authoritarian scale's (Adorno, et. al., 1950) primary focus was to measure an individual's preoccupation with power and strength (r = .37). The Rigidity About Personal Habits construct (Neuberg & Newsom, 1993) measures traditionalism, rule boundaries and discomfort and opposition to change (r = .62). When compared to the Personal Need for Structure Scale (Thompson, et. al., 1993), a correlation coefficient of .29 was found with Depression and .14 with the Self-Consciousness scales used (Neuberg & Newsom, 1993). Overall, personal need for structure was found to be a distinct construct only mildly related to other individual difference constructs.

The internal consistency of the Personal Need for Structure Scale (Thompson, et al., 1993) was found to be .83, $p < .01$ (Cronbachs α; n = 973) by Roman, Moskowitz, Stein and Eisenberg (1992). It's reliability, with an alpha coefficient of .84, and item-total correlation of between .42 and .62 is adequate for the purposes of this research. The Personal Need for Structure Scale was explored for Test-

Retest reliability and found to be $r = .84$, $p < .01$ at two months (Neuberg & Newsom, 1992).

Work Environment Form

The Work Environment Form (Rivera, 1994) was specifically constructed by the investigator to measure perceived stress, perceived social support, and perceived predictability of work related events along with demographic information (see appendix K). It consists of 77-items chosen from an initial group of 90 items. The initial item set was generated from informal discussions with forensic psychiatric workers who were no longer at the facility. They were asked to identify and discuss stressful factors related to working with forensic psychiatric patients. These comments were organized into a 90-item questionnaire that was informally and formally evaluated by a sample of retired mental health aides and nurses. Many of these evaluators described the importance of supportive peer relationships and administrative supports. Others focused on predictability of patient behaviors and the "inherent" stressfulness of their jobs. The evaluators responses to the questionnaire items were helpful with respect to refining the instrument. The items which were considered to be theoretically and statistically most relevant to the research questions (social support from networks and the administration, and predictability) were utilized. As noted in Chapter II, these areas are frequently seen as

contributing to work stress in intensive patient contact/care facilities (Corrigan, 1993) and in public psychiatric hospitals. As such, feedback from forensic psychiatric workers related to their experiences will hopefully contribute to our understanding of coping responses and personal need for structure in this population of mental health care providers.

The Work Environment Form (Rivera, 1994), is organized into four sections: perceived stress; social support; predictability; and demographic information. Three of the scales were designed to assess an individual's perception of stress, social support and predictability. On each of the three scales, the participants rate each item, indicating on a scale from one to five, to what degree they agree with each statement, except for the open demographic items. A response of 1 indicated that the individual strongly disagreed with the statement, whereas, a 5 indicated that the individual strongly agreed. The remaining scale consisted of demographic items related to the respondents (i.e., age, gender, etc.).

The perceived stress items (18) asked the respondent to indicate to what degree they believed themselves to be experiencing stress or stress symptoms. The manner in which an individual responded to these items indicated the average level of life stress they were perceiving at the time of the survey. For this 18-item scale, a score between 18 to 90

was possible, with 18 indicating the lowest and 90 indicating the highest index of perceived stress.[3]

The perceived social support items (20) allowed the respondent to indicate to what degree they valued or utilized their social network (family, friends, co-workers, facility administrators, etc.). The respondent indicated to what extent he/she perceived his/her social network as supportive (available for companionship, guidance, intimacy). The individual's cumulative index suggested to what degree they experienced support from their social network and to what degree they feel it is important to them. For this 20-item scale, a score between 20 to 100 was possible, with 20 indicating the lowest, and 100 indicating the highest index of perceived social support.[4]

The perceived predictability items (16) were crafted to assess the degree to which the individual perceived a predictable daily life routine. These items indicate whether or not an individual saw his/her life as being regimented and orderly, and how comfortable he/she is with predictability. For this 16-item scale, a score between 16 to 80 was possible; 18 indicating the lowest, and 80 indicating the highest index of perceived predictability.[5]

The demographic (and other) information items (22) were limited by the laws restricting inquiry related to the race,

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[3]Same note.
[4]Same note.
[5]Same note.

age, gender, and marital status of New York State employees. These restricted questions were made optional for respondents. Other demographic questions consisted of overtime hours worked, work experience, retirement, years of education, feelings related to perceived dangerousness of patients, number of social meetings with friends over the week, etc. In sum, the overall purpose of the Work Environment Form (Rivera, 1994) was to examine the respondent's perceptions of stress, social support, and predictability, as well as to provide demographic information.

Procedures

Each participant received the survey materials at the beginning of their shift. The survey materials consisted of the Coping Inventory For Stressful Situations (Endler & Parker, 1990a), the Personal Need for Structure Scale (Thompson, et al., 1993), the Work Environment Form (Rivera, 1994), a duplicate Notice of Informed Consent and an envelope (see appendix G, I-K). These forms were all stapled together, folded and placed in an envelope. The duplicate copies of the Notice of Informed Consent were stapled to the back of each envelope. Prior to answering the survey, each prospective respondent removed both consent forms from the envelope and read them. Upon full disclosure of possible risks and benefits, each respondent signed the duplicate copies of the Notice of Informed Consent and

retained a copy for their records. The other copy was returned to the researcher. Each participant was asked if they had any questions regarding any aspect of the research project. After the researcher responded to questions regarding the project, the respondents were instructed to respond to the surveys. They were told that the surveys would be collected at the end of their shifts during a two-week interval of time. When the survey was returned, each respondent received a $10 cash participation payment from the researcher. Participants spent approximately 15-minutes on the survey.

As noted earlier, a ten dollars ($10) participation payment was offered in an attempt to optimize the response rate. Although each survey was examined before the participation payment was offered, several surveys were discarded because they did not appear accurate (i.e., age of 85, suspected response sets, etc.,). In an effort not to contaminate the data set these surveys were not used.

Finally, it should be noted that the participants were offered an opportunity to receive feedback upon completion of the study. In the Notice of Informed Consent all respondents were reminded that their Employee Assistance Program (EAP) offers referrals for stress management should they need to further address this issue.

Data Analyses

The data were analyzed in order to determine if the level of personal need for structure is related to coping preferences (task-, emotion- or avoidance-oriented) and perceived social support, stressor and predictability. Although a path analytic procedure was initially planned, the number of respondents fell below 100 subjects, and the alternative method of correlational analyses and multiple regression analyses were utilized.

CHAPTER IV

RESULTS

Introduction

The overall purpose of this study was to assess the relationships among coping responses, personal need for structure, and perceptions of predictability, social support and stress related to coping preferences. The resulting data were analyzed to: (1) determine the relationship between personal needs for structure and coping styles; (2) to describe the nature of personal needs for structure of forensic psychiatric workers; and (3) to assess the degree to which perceptual factors are related to coping preferences. Personal needs for structure and perceptual factors were the independent variables in the study and coping preference style (emotion-, task-, and avoidance-oriented) was the dependent variable in two of these groups. Statistical descriptions of the relationship between coping response preferences, personal needs for structure, and perceptual factors are discussed in a summary description of the variables is presented in Table 1.

Sample Characteristics

The sample characteristics examined in this study were in both personal and work related areas. Personal variables

TABLE 1

SUMMARY OF OUTCOME VARIABLES

Variable Name	Variable Type	Measure Used	Number of Items[a]	Type of Scale[b]
Personal and Work-Related	Controlled for	Work-Environment Form	10	Open
Personal Need for Structure	Independent	Personal Need for Structure Scale	11	Likert
Perceived Stress	Independent	Work-Environment Form	23	Likert & Open
Perceived Predictability	Independent	Work-Environment Form	14	Likert & Open
Perceived Social Support	Independent	Work-Environment Form	23	Likert & Open
Task-Oriented coping response	Dependent	Coping Inventory For Stressful Situations	16	Likert
Avoidance-Oriented coping response	Dependent	Work-Environment Form	16	Likert
Emotion-Oriented coping response	Dependent	Work-Environment Form	16	Likert

Note.
[a]Only the final number of items included in each scale after scale construction are included.
[b]Likert = likert-like response format. Open = an open ended response format. Likert & Open = a combination of likert-like and open ended response format styles.

of the respondents included demographic items (i.e., age, race, gender, marital status, and level of education), as well as other behavioral items (i.e., social life and/or number of times the person goes out with friends). These items consisted of open-ended, one or two word responses to the questions appearing at the end of the Work Environment Form (Rivera, 1994). Work related variables included job title, work shift, overtime work, average weekly overtime worked, likelihood of patient assault, time at most risk, number of weekly incidents, years working with this population, years at facility, and retirement plans. A brief summary of outcome variables is provided in Table 1.

Originally, a projected sample of at least 100 was sought to allow for an adequate sample for application of a path analysis procedure to the data set. However, only 84 usable responses were attained. Due to the smaller than expected sample size, a combination of correlational and multiple regression analyses were performed instead. Simple correlational analyses were used to test for significant bivariate relationships. When more than two independent variables were used in the same analyses, a multiple regression analysis procedure was used. This statistical procedure yielded the best linear combination of independent variables (i.e., personal needs for structure, perceived predictability, perceived stress, perceived social support)

that would predict each of the three dependent measures (i.e., the coping styles of emotion, task, and avoidance). When differences were found within the group of forensic psychiatric workers, additional, more fine-grained analyses were conducted comparing the responses of the nurses with the responses of the mental health aides.

Hospital Environment

At the time of the data collection there were six secured units as well as a tentative plan to open further units in the facility. There were no significant changes in the nursing requirements as specified through the nursing contract. The mental health aides, however, were in the midst of re-negotiating certain features within their contract with regard to their early retirement policies. No other changes were pending at the facility at the time of data collection.

The forensic psychiatric workers were permanently assigned to one unit within the facility. There were some forensic psychiatric workers who acted as 'floaters.' They were stationed at alternating units depending on the personnel needs at the facility. For the most part, each unit was staffed by one full-time social worker, a part-time psychologist, and a psychiatrist. The ratio of forensic psychiatric workers to patients was approximately 1:5 at the time of data collection.

All the patients capable of engaging in daily activities (i.e., library use, gym time, movie viewing, organized games/sports activities, workshops, jobs, etc.) were escorted in groups to these activities. They were also involved in out-door activities during days when the weather permitted. The patients ranged in ages from 19 to 64 years of age, with various lengths of stay and psychiatric disorders. The patient population was primarily English-speaking adults who had been court mandated to the facility. They had been decreed to be in need of psychiatric treatment and/or monitoring because they were either unfit to stand trial or found not-guilty because of a 'mental disease or defect.'

In addition to the supervision and care provided, forensic psychiatric workers were also involved in weekly case conferences, in-service training, and daily shift briefings. Although active in the daily operations of the facility, their input in administration or policy formulation was minimal. Generally speaking it appeared that forensic psychiatric workers had many opportunities for continuous training and skill development.

Personal Variables

As can be seen in Table 2, subjects ranged in age from 24 to 59 with an average age of 40 years (SD = 1.08). Fifty-seven percent of the respondents were male and 43 percent were female. A majority of the respondents were African American (66 percent), 14 percent were Asian, eight percent were Hispanic, six percent were White, and six percent indicated Other. Almost half of the respondents (45 percent) were married; 38 percent were single; 14 percent were divorced; one percent were widowed; and, one percent were separated.

Twenty-one percent of the subjects had attained a high school diploma (or it's equivalence), 67 percent had attended some college, and 13 percent had completed at least some graduate level training. Thus, the sample appears to be fairly well educated.

In an effort to assess their level of socializing, the subjects were also asked to report how many times they went out with close friends. The level of social contacts they had outside the institution appeared to be significant. Overall, a majority of respondents (82 percent) stated that they went out once or twice a week with close friends. The remaining 18 percent reported that they went out three or more times a week with close friends. Thus this sample of respondents does not appear to be socially isolated.

TABLE 2

SAMPLE CHARACTERISTICS

Variables	Frequency	Percent	Valid Percent
Personal Variables			
Age[a]			
24-34	15	18.0	25.1
35-45	32	38.3	53.5
46-59	13	15.6	21.8
Missing	24	28.6	Missing
TOTAL	84	100	100
Race			
Black	52	61.9	65.8
Asian	11	13.1	13.9
Hispanic	6	7.1	7.6
White	5	6.0	6.3
Other	5	6.0	6.3
Missing	5	6.0	Missing
TOTAL	84	100	100
Gender			
Male	45	53.6	57.0
Female	34	40.5	43.0
Missing	5	6.0	Missing
TOTAL	84	100	100
Marital Status			
Single	29	34.5	38.2
Married	34	40.5	44.7
Divorced	11	13.1	14.5
Separated	1	1.2	1.3
Windowed	1	1.2	1.3
Missing	8	9.5	Missing
TOTAL	84	100.0	100
Years of Education[b]			
12	13	15.5	20.6
13	3	3.6	4.8
14	13	15.5	20.6
15	7	8.3	11.1
16	19	22.6	30.2
17	5	6.0	7.9
18	3	3.6	4.8
Missing	21	25.0	Missing
TOTAL	84	100	100
Plans to Retire			
Yes	44	52.4	57.1
No	33	39.3	42.9
Missing	7	8.3	Missing
TOTAL	84	100	100

TABLE 2

SAMPLE CHARACTERISTICS -- CONTINUED

Variables	Frequency	Percent	Valid Percent
Personal Variables			
Time with Friends[c]			
One	32	38.1	48.5
Two	22	26.2	33.3
Three	7	8.3	10.6
Four	3	3.6	4.5
Five or More	2	2.4	3.0
Missing	18	21.4	Missing
TOTAL	84	100	100
Variables			
Work-Related Variables			
Job Title			
Mental Aide	53	63.1	73.6
Nurse	19	22.6	26.4
Missing	12	14.3	Missing
TOTAL	84	100	100
Work Shift			
Day (7am - 3:30pm)	38	45.2	46.9
Evening (3pm - 11:30pm)	36	42.9	44.4
Nights (11pm - 7:30am)	7	8.3	8.6
Missing	3	3.6	Missing
TOTAL	84	100	100
Over-Time Worked Today			
Yes	16	19.0	20.5
No	62	73.8	79.5
Missing	6	7.1	Missing
TOTAL	84	100	100
Average Over-Time Weekly[d]			
0 - 4 hrs	37	44.1	50.1
7 - 12 hrs	19	22.7	25.8
16 - 24 hrs	16	19.1	21.7
32 - 40 hrs	2	2.4	2.8
Missing	10	11.9	Missing
TOTAL	84	100	100
Likelihood of Assault			
Yes	61	72.6	74.4
No	21	25.0	25.6
Missing	2	2.4	Missing
TOTAL	84	100	100

TABLE 2

SAMPLE CHARACTERISTICS -- CONTINUED

Variables	Frequency	Percent	Valid Percent
Time at Most Risk			
AM	10	11.9	13.5
PM	23	27.4	31.1
Not Predictable	29	34.5	39.2
Other time	12	14.3	16.2
Missing	10	11.9	Missing
TOTAL	84	100	100
Number of Incidents[e]			
None	3	3.6	3.7
One	21	25.0	25.6
Two	18	21.4	22.0
Three	19	22.6	23.2
Four	4	4.8	4.9
Five or More	17	20.2	20.7
Missing	2	2.4	Missing
TOTAL	84	100	100
Years of Patient Work[f]			
1 - 5	12	14.4	18.0
6 - 10	30	36.8	44.8
12 - 15	12	14.4	18.0
16 - 20	6	7.2	9.0
22 - 28	4	6.0	7.5
30 - 32	3	2.4	3.0
Missing	17	20.2	Missing
TOTAL	84	100	100
Years at Facility[g]			
1	13	16.7	17.5
2	3	3.6	3.8
3	6	7.1	7.5
4	11	13.1	13.8
5	8	9.5	10.0
6	3	3.6	3.8
7	3	3.6	3.8
8	7	8.3	8.8
9	17	20.2	21.3
10	8	9.5	10.0
Missing	5	4.8	Missing
TOTAL	84	100	100

Note. [a]$\underline{M}$ = 39.7, $\underline{SD}$ = 1.08; [b]$\underline{M}$ = 14.7, $\underline{SD}$ = 1.80; [c]$\underline{M}$ = 1.8, $\underline{SD}$ = 1.01; [d]$\underline{M}$ = 7.1, $\underline{SD}$ = 8.41; [e]$\underline{M}$ = 2.6, $\underline{SD}$ = 1.53; [f]$\underline{M}$ = 11.3, $\underline{SD}$ = 6.94; [g]$\underline{M}$ = 5.6, $\underline{SD}$ = 3.19.

Work Related Variables

The work-related variables investigated, consisted of job title, work shift, overtime work, average weekly overtime worked, likelihood of patient assault, time at most risk, number of weekly incidents, years working with this population, years at facility, and retirement plans. The forensic psychiatric worker sample was comprised of mental health aides and nurses. The results for the sample are listed in Table 3.

Of the 84 respondents, mental health aides made up 74 percent of the respondents; 26 percent of the respondents were nurses. Forty-seven percent of all the respondents in the study worked the day shift, forty-four percent of the respondents worked the evening shift, and nine percent of the respondents worked the midnight shift.

The respondents were asked if they planned to work overtime the day the data was collected. Eighty percent of respondents did not work overtime on the day the survey was completed, 20 percent did. For the most part, of the respondents who occasionally worked overtime, 50 percent worked up to four hours of overtime per week. Twenty-five percent of the workers indicated that they worked between seven and twelve hours of overtime per week. Twenty-three percent reported working between 16 and 24 hours of overtime per week. Two percent of these workers, indicated that they worked between 32 and 40 hours of overtime per week. The

average forensic psychiatric worker in the sample reported working several of hours of weekly overtime.

When the respondents were asked to indicate their perception of threat from patients, the majority, 74 percent, believed that the patients were likely to assault them, while only 26 percent believed that they were unlikely to be assaulted. It appears that most of the forensic psychiatric workers believed that the patients posed a threat of physical harm to them.

When respondents were asked at what time they felt most at risk, 61 percent indicated that they could predict the time they would be at most risk; 39 percent felt that assault time was not predictable. Respondents reported feeling at risk most during patient meals and when medication was distributed. In sum, there appears to be a perceived threat and/or risk of harm by patients during organized patient movements and/or activities.

When respondents were asked how many patient incidents they experienced in an average week, 49 percent reported that they experienced three or more incidents weekly. Forty-seven percent reported experiencing an average of up to two patient incidents per week, four percent reported that no weekly incidents were experienced. The incidents that were reported to be observed by forensic psychiatric workers included a patient's attack on others (patient or staff), destruction of property, verbal altercations, and

self-injurious behaviors. Ninety-eight percent observed one to two instances of patient aggression and acting out responses per week, thus confirming that the workplace and work conditions are perceived as dangerous, stressful and potentially volatile.

Respondents indicated varying degrees of experience working with this patient population. The total number of years working with this population ranged from one to thirty-two years, with the average being 11.3 years (SD = 6.94).

In summary, a review of the personal variables indicated that the respondents were, on the average, about 40 years old, married, African American males with some college education. The respondents appeared to be socially active and went out once or twice a week with close friends.

At the time of the data collection, the subject facility had been open for ten years. Fifty-two percent of the respondents indicated that they had been at the facility for less than five years, 48 percent had been at the facility between five and ten years. About 57 percent of the respondents indicated that they planned to retire soon (see Table 2).

Scale Construction and Reliability Analyses

Scale Construction

Seven scales were constructed, four for the independent variables (personal need for structure, perceived stress, perceived social support and perceived predictability), and three for the dependent variables (task-, avoidance-, and emotion-oriented coping). It should be noted that the items for each subscale were summed and the result was divided by the total number of items in each subscale to convert the scale back into it's original units of measurement. For each subscale, items were correlated with the total scale were. These differential correlations provide a better understanding of the meaning of each subscale (i.e., items that correlated the highest with total scale contributed more to the scale's meaning). The item correlations with the total scale are reported in Appendix K for each of the seven scales. Items were eliminated from each scale when they were found not to contribute to the scale and/or enhance reliability.

During the systemic review of each subscale, it was necessary to revise two scales to permit a better understand of the data sets. Specifically, one item was eliminated from the Personal Need for Structure Scale (Thompson, et al., 1993), and two items were eliminated from the emotion-oriented scale of the Coping Inventory of Stressful Situations (Endler & Parker, 1993a) because they

were found to be outside of what was expected. These slightly revised scales were used in the final analyses of the data sets.

Reliability Estimates

Estimated internal consistency reliability for the scales in the sample are given in Table 3. They ranged from .52 to .88. The weakest reliability estimates were found to be for the perceived stress (Cronbach's α = .52) and perceived social support (Cronbach's α = .54) scales. It should be noted that these were two of the scales constructed by the researcher. The reliability estimates for the more well established scales the Personal Need for Structure Scale (Thompson, et al., 1993) and the Coping Inventory For Stressful Situations (Endler & Parker, 1990) subscales (emotion, task, avoidance), were found to be consistent with what is reported in the literature (alphas = .75 to .86).

Personal Need For Structure Scale (Thompson, et al., 1993)

The mean obtained on the measure used for the Personal Need For Structure Scale (Thompson, et al., 1993), was remarkably high (M = 4.37, SD = .677). Given this finding, respondents, as a group, tended to have relatively high personal need for structure (desire for simple structure) in their daily lives.

The Work Environment Form (Rivera, 1994)

The Work Environment Form (Rivera, 1994) was used to assess the respondents' perceptions of social support, stress and predictability. The Work Environment Form subscales yielded moderately high mean scores which reflect a rather high level of perceived social support (M = 3.25, SD = .54), perceived stress (M = 3.69, SD = .49), and perceived predictability (M = 3.81, SD = .45). These results indicate that forensic psychiatric workers on the whole, tend to perceive high levels of social support, stress, and predictability in their daily life.

The Coping Inventory For Stressful Situations (Endler & Parker, 1990)

The findings indicated that, as a group, respondents tended to utilize more task-oriented coping responses. The emotion-, task-, and avoidance-oriented coping response scales exhibited greater variance than the other scales. On the emotion-oriented coping preference scale, respondents expressed moderate use of this coping preference (M = 2.67, SD = .68). On the avoidance-oriented coping preference scale, respondents utilized this coping style somewhat more frequently (M = 3.16, SD = .74). Finally, on the task-oriented scale respondents most frequently selected the more active approach to stressful situations (M = 4.03; SD = .52). Taken together these results indicate that forensic psychiatric workers tend to more often utilize task-oriented coping responses when confronted with stress.

In sum, the respondents, as a group, tended to have: a high personal need for structure; moderately elevated perceptions of social support, stress, and predictability; and used a task-oriented coping response more than emotion- or avoidance-oriented coping. These results are reported in the following section, and are numbered for each hypothesis tested. Subjects responses on the dependent measures were reviewed and are summarized in Table 3.

TABLE 3

ESTIMATED INTERNAL CONSISTENCY RELIABILITY FOR THE MEASURES USED IN THE STUDY

Variables	n	M	SD	Cronbach's α
Independent Variable				
Personal Need for Structure	82	4.37	.68	.75[a]
Perceived Social Support†	83	3.25	.54	.54[b]
Perceived Stress†	83	3.69	.49	.52[b]
Perceived Predictability†	84	3.81	.45	.85[b]
Dependent Variables				
Emotion-Oriented	84	2.67	.68	.88[b]
Task-Oriented	84	4.03	.52	.83[b]
Avoidance-Oriented	84	3.16	.74	.86[b]

Note. All scales, except for Personal Need for Structure, have five as the highest score; Personal Need for Structure has six. The higher the score the greater the reported level of the construct.

[a]Based on a sample size of 81.
[b]Based on a sample size of 60.
†Constructed by the researcher for the study.

Correlational Analyses

The first six hypotheses in this study were tested using a correlational analysis procedure. The results of the correlation analyses are summarized in Table 4. Intercorrelations among the dependent measures (emotion-, task-, and avoidance-oriented coping responses) and the independent variables (a personal need for structure, perceived stress, perceived predictability, and perceived social support) were obtained. An examination of these intercorrelations, indicated that there was a relationship between two of the dependent measures [emotion- and avoidance-oriented coping (r = .321, p = .01)]. The independent variables were also found to be interrelated. Perceived predictability was found to be significantly correlated with personal need for structure(r = .372, p = .01), perceived stress was significantly correlated with perceived predictability (r = .281, p = .01), and social support was negatively correlated with stress (r = -.268, p = .05).

The first three hypotheses (stated in the null) dealt with an examination of the relationship of a personal need for structure and the three dependent measures (perceived stress, perceived predictability, and perceived social support).

The first hypothesis (in it's null form) posited that there was no relationship between a personal need for

structure and perceived predictability. The results indicated that perceived predictability was positively correlated with personal need for structure (r = .372, p < .01). That is, respondents who were high in need for personal structure were also found to be high on perceived predictability.

The second hypothesis (in it's null form) posited that there was no relationship between personal need for structure and perceived stress. A personal need for structure was not found to be significantly correlated with perceived stress (r = .206, p = .06).

The third null hypothesis posited that there was no relationship between personal need for structure and perceived social support. The results indicated that a personal need for structure was not significantly correlated with perceived social support (r = .165, p = .14).

Another set of three hypotheses dealt with an examination of the relationship between a personal need for structure and the three coping responses (emotion-, task-, avoidance-oriented). The first hypothesis of this set (the fourth hypothesis), posited that there was no relationship between personal need for structure and task-oriented coping responses (again stated in it's null form). It was found that personal need for structure was positively related to task-oriented coping response (r = .412, p < .01). That is, respondents who were high in personal need for structure

tended to use task-oriented coping to deal with stress (e.g., get control over situation, schedule time better, analyze their problem). Given what is understood of personal need for structure, this result suggests that the task coping style is compatible with having a personal need for structure in one's daily life.

The fifth null hypothesis posited that there was no relationship between personal need for structure and avoidance-oriented coping responses. The results indicated that personal need for structure was not significantly correlated with avoidance-oriented coping response (r = .124, p = .26).

The sixth null hypothesis posited that there was no relationship between personal need for structure and emotion-oriented coping responses. Personal need for structure was not found to be significantly correlated with emotion-oriented coping response (r = .120, p = .28).

TABLE 4

CORRELATION BETWEEN INDEPENDENT VARIABLES AND DEPENDENT MEASURES

Scale	1	2	3	4	5	6	7
1. PNS	--						
2. Predictability	.372**	--					
3. Stress	.206	.281**	--				
4. Social Support	.165	.130	-.268*	--			
5. Task	.412**	.278**	.047	.176	--		
6. Avoidance	.124	.036	.042	.284**	.200	--	
7. Emotion	.120	.175	.427**	.159	-.081	.321**	--

Note. PNS = Personal Need for Structure; Predictability = Perceived Predictability; Stress = Perceived Stress; Social Support = Perceived Social Support; Emotion = Emotion-oriented coping response; Task = Task-oriented coping response; and Avoidance = Avoidance-oriented coping response. Missing data are excluded pairwise.

*p < .05. **p < .01.

Regression Analyses

The next aim was to find the best predictors among the independent variables for each particular coping response preference (emotion-, task-, and avoidance-oriented). The final three hypotheses were tested using stepwise regression procedures. With stepwise regression, the independent variable that best predicts the dependent variable is entered into the regression equation first. Independent variables that add unique variance to the prediction of the dependent variable are then entered. A listwise procedure for treating missing data was used. Only those respondents who provided information for all the variables in each analysis were included in the regression analysis.

One regression analysis was run for each of the three dependent measures. Personal need for structure, perceived predictability, perceived stress, and perceived social support were used as the independent variables in each of the analyses. The last three hypotheses sought to delineate the best predictors of coping response preference.

Hypothesis seven posited that there were no clear predictors of task-oriented coping in relation to the independent variables (personal need for structure, perceived predictability, perceived stress, and perceived social support). Results indicated that taken together, the independent variables predicted task-oriented coping (F(2,

77) = 13.41, $p < .01$). In particular, personal need for structure ($t = 3.910$, $p < .01$) and perceived predictability ($t = 2.017$, $p < .05$) were found to be significant predictors of task-oriented coping response (see Table 5). As personal need for structure increased, task-oriented coping responses increased.

Hypothesis eight posited that there were no clear predictors of avoidance-oriented coping in relation to the independent variables (personal need for structure, perceived predictability, perceived stress and perceived social support). The results showed that taken together the independent variables, predicted avoidance-oriented coping ($F(1, 78) = 5.48$, $p > .05$), but that social support was found to be the only significant predictor ($t = 2.341$, $p < .05$) of avoidance-oriented coping responses (see Table 6). That is, as perceived social support increases, so does avoidance-oriented coping.

The last hypothesis, nine, posited that there were no clear predictors of emotion-oriented coping in relation to the independent variables (personal need for structure, perceived predictability, perceived stress, and perceived social support). Results showed that the combination set of independent variables, predicted emotion-oriented coping ($F(2, 77) = 14.57$, $p < .01$). In particular, perceived stress ($t = 5.159$, $p < .01$) and perceived social support (t

= 2.997, $p < .05$) were found to be the best predictors of an emotion-oriented coping styles. As perceived stress and perceived social support increase, emotion-oriented coping style increased (see Table 7). Overall, these regression analyses yielded results showing clear predictors of differential coping response preference.

TABLE 5

STEPWISE REGRESSION ANALYSIS FOR TASK-ORIENTED COPING

Variables in the Equation

Variable	B	Se B	β	T	Sig T
Personal Need For Structure	.326	.084	.404	3.91	.000**
Perceived Predictability	.251	.125	.208	2.02	.047*

Variables not in the Equation

Variable	Beta In	Partial	Min Toler	T	Sig T
Perceived Stress	-.103	-.113	.853	-.994	.323
Perceived Social Support	.075	.085	.888	.746	.458

Note. R = .508, R^2 = .258, Adjusted R^2 = .239, $F(2, 77)$ = 13.41, p < .01.

*p < .05. **p < .01.

TABLE 6

STEPWISE REGRESSION ANALYSIS FOR AVOIDANCE-ORIENTED COPING

Variables in the Equation

Variable	B	Se B	β	T	Sig T
Perceived Stress	.356	.152	.256	2.34	.022*

Variables not in the Equation

Variable	Beta In	Partial	Min Toler	T	Sig T
Personal Need for Structure	.157	.160	.973	1.426	.158
Perceived Predictability	.052	.053	.984	.468	.641
Perceived Social Support	.130	.129	.918	1.142	.257

Note. R = .256, R^2 = .066, Adjusted R^2 = .054, $F(1, 78)$ = 5.48, p = .02.

*$p < .05$.

TABLE 7

STEPWISE REGRESSION ANALYSIS FOR EMOTION-ORIENTED COPING

Variables in the Equation

Variable	B	Se B	β	T	Sig T
Perceived Stress	.716	.139	.523	5.159	.000**
Perceived Social Support	.387	.129	.304	2.997	.004**

Variables not in the Equation

Variable	Beta In	Partial	Min Toler	T	Sig T
Personal Need For Structure	.019	.021	.853	.182	.856
Perceived Predictability	.045	.049	.813	.428	.670

Note. R = .524, R^2 = .275, Adjusted R^2 = .256, $F(2, 77)$ = 14.57, p < .01.

**p < .01.

Secondary Analyses

Upon completion of the initial analyses, difference within the group of forensic psychiatric workers were noted. Specifically, there were more female nurses and most of the forensic psychiatric workers were found to be African Americans. How do these differences effect the findings reported thus far? The difference between the coping response of the mental health aides and the nurses were examined further through a series of secondary analyses.

No significant findings were documented among the demographic variables. It was believed that years of experience working with psychiatric forensic patients would influence their beliefs and thereby their perceptions of stress and predictability. The more experience an individual has at a particular job is generally believed to coincide with a greater level of skill or knowledge. The number of years worked with this population of patients was seen as a factor which might have influenced predictability and in turn the selection of a coping response.

The results indicated that there were no significant differences in the coping preferences of forensic psychiatric workers with regard to number of years employed within the facility. It is unclear as to what effect the respondents misunderstanding of the number of years of experience questions influenced this finding.

Additional analyses were conducted when differences between mental health aides and nurses were discovered in the respondents' perceived level of social support, and task- and avoidance-oriented coping preferences. Results from a series of independent group t-tests showed that nurses' perception of social support was greater than that reported by the mental health aides ($t(71) = -2.11$, $p < .05$). Nurses were found to use both task- ($t(53) = -3.70$, $p < .01$) and avoidance-oriented ($t(71) = -2.85$, $p < .01$) coping responses more than mental health aides in the initial analyses.

Correlational values among the independent and dependent variables were systematically examined for both groups. The patterns of relationships among the variables were found to be differed across groups [mental health aides and nurses (see Table 8)]. Significant correlations were found between personal need for structure and a task-oriented coping preference ($r = .443$, $p < .01$) for the mental health aides. A significant correlation between perceived stress and emotion-oriented coping preference ($r = .421$, $p < .01$) was also noted. In addition, perceived predictability and task-oriented coping preference ($r = .415$, $p < .01$) were found to be significantly related.

Correlations for nurses indicated that a relationship existed between personal need for structure and task-

oriented coping (r = .511, p = .013). Perceived stress was significantly related to emotion-oriented coping style in nurses (r = .621, p = .002). In contrast to the nurses, a significant relationship was found between perceived predictability and task-oriented coping for the mental health aides. Thus it appears that employment position (nurse vs. mental health aide) moderated the relations between perceived predictability and the use of task-oriented coping response (i.e., the relation is stronger among mental health aides than among nurses.)

TABLE 8

MEANS AND STANDARD DEVIATIONS OF MENTAL HEALTH AIDES AND NURSES ON THE INDEPENDENT VARIABLES AND DEPENDENT MEASURES

	Mental Health Aides			Nurses					
Variable	n	M	SD	n	M	SD	t	df	signif
PNS	51	4.34	.73	19	4.56	.47	-1.39	70	.170
SS	51	3.15	.57	19	3.46	.48	-2.11	70	.038*
PS	51	3.73	.48	19	3.58	.52	1.11	70	.269
PP	51	3.81	.46	19	3.88	.32	-.56	70	.579
EMOTION	51	2.60	.70	19	2.72	.62	-.48	70	.631
TASK	54	3.89	.56	19	4.29	.33	-3.70	73	.005**
AVOIDANCE	54	2.92	.74	19	3.54	.58	-2.85	73	.006**

Note. PNS = Personal Need for Structure; PP = Perceived Predictability; PS = Perceived Stress; SS = Perceived Social Support; Emotion = Emotion-oriented coping response; Task = Task-oriented coping response; and Avoidance = Avoidance-oriented coping response.

* $p < .05$. ** $p < .01$.

TABLE 9

CORRELATION BETWEEN THE INDEPENDENT VARIABLES AND THE DEPENDENT MEASURES

Scale	1	2	3	4	5	6	7
			Nurses (n = 19)				
1. PNS	--						
2. Predictability	.209	--					
3. Stress	.267	.156	--				
4. Social Support	-.018	.046	-.119	--			
5. Task	.511*	.152	.156	-.028	--		
6. Avoidance	-.175	-.032	.173	.221	-.118	--	
7. Emotion	.209	.369	.621**	-.122	-.186	.299	--
			Mental Health Aides (n = 52)				
1. PNS	--						
2. Predictability	.340**	--					
3. Stress	.288	.388	--				
4. Social Support	.166	.198	-.330	--			
5. Task	.443**	.415	.120	.133	--		
6. Avoidance	.221	.115	.009	.216	.183	--	
7. Emotion	.162	.191	.421	.211	-.076	.233	--

Note. Missing data are excluded pairwise.
*$p < .05$. **$p < .01$.

A review of stepwise multiple regression procedures were conducted to determine the best predictors of two of the three coping responses (emotion- and task-oriented) for the nurses and the mental health aides. Since none of the independent variables were found to be significantly correlated with an avoidance-oriented coping style, stepwise regression analyses were not computed for this dependent measure.

Emotion-Oriented Coping

The findings from the regressions indicated that emotion-oriented coping is significantly influenced by the perception of social support and stress. In mental health aides, both independent variables were found to be significant as predictors; in nurses, perceived stress was found to be the best predictor of emotion-oriented coping. For mental health aides, the best predictors of emotion-oriented coping were found to be perceived stress (t = 4.445, $p < .01$) and perceived social support (t = 3.171, $p < .01$; see Table 10). Apparently, as perceived social support and stress increased, emotion-oriented coping increases. For nurses, the best predictor of this type of coping was perceived stress (t = 3.270, $p < .01$). As perceived stress increased, emotion-oriented coping increased (see Table 11).

TABLE 10

STEPWISE REGRESSION ANALYSIS FOR
EMOTION-ORIENTED COPING FOR MENTAL HEALTH AIDES

Variables in the Equation

Variable	B	Se B	β	T	Sig T
Perceived Stress	.811	.182	.567	4.445	.000**
Perceived Social Support	.506	.160	.404	3.171	.003**

Variables not in the Equation

Variable	Beta In	Partial	Min Toler	T	Sig T
Personal Need For Structure	-.082	-.091	.747	- .628	.533
Perceived Predictability	-.158	-.162	.647	-1.130	.264

Note. R = .566, R^2 = .320, Adjusted R^2 = .292, $F(2, 48)$ = 11.30, p < .05.

**p < .01.

TABLE 11

STEPWISE REGRESSION ANALYSIS FOR EMOTION-ORIENTED COPING FOR NURSES

Variables in the Equation

Variable	B	Se B	β	T	Sig T
Perceived Stress	.738	.226	.621	3.370	.004**

Variables not in the Equation

Variable	Beta In	Partial	Min Toler	T	Sig T
Personal Need for Structure	.046	.057	.928	.228	.822
Perceived Predictability	.278	.351	.976	1.500	.153
Perceived Social Support	-.049	-.062	.868	-.250	.806

Note. $R = .621$, $R^2 = .386$, Adjusted $R^2 = .350$, $F(1, 17) = 10.70$, $p = .004$.

**$p < .01$.

Task-Oriented Coping

Personal need for structure was found to play a significant role for both mental health aides and nurses. For the mental health aides, personal need for structure and perceived predictability ($t = 2.460$, $p < .05$) were found to be the best predictors of task-oriented coping (see Table 12). For nurses, personal need for structure ($t = 2.449$, $p < .05$) was the best predictor of task-oriented coping (see Table 13). Thus, for nurses, as personal need for structure increased task-oriented coping increased. For mental health aides, as personal need for structure and perceived predictability increased, task-oriented coping increased.

TABLE 12

STEPWISE REGRESSION ANALYSIS FOR
TASK-ORIENTED COPING FOR MENTAL HEALTH AIDES

Variables in the Equation

Variable	B	Se B	β	T	Sig T
Personal Need For Structure	.262	.100	.338	2.616	.012*
Perceived Predictability	.384	.156	.318	2.460	.018*

Variables not in the Equation

Variable	Beta In	Partial	Min Toler	T	Sig T
Perceived Stress	-.128	-.137	.789	- .951	.347
Perceived Social Support	.009	.010	.865	.071	.944

Note. R = .538, R^2 = .289, Adjusted R^2 = .259, $F(2, 48)$ = 9.76, p = .0003.

*$p < .05$.

TABLE 13

STEPWISE REGRESSION ANALYSIS FOR TASK-ORIENTED COPING FOR NURSES

Variables in the Equation

Variable	B	Se B	β	T	Sig T
Personal Need for Structure	.363	.148	.511	2.449	.026*

Variables not in the Equation

Variable	Beta In	Partial	Min Toler	T	Sig T
Perceived Predictability	.047	.053	.956	.213	.834
Perceived Stress	.021	.024	.928	.095	.925
Perceived Social Support	-.019	-.022	1.000	-.088	.931

Note. $R = .511$, $R^2 = .261$, Adjusted $R^2 = .217$, $F(1, 17) = 6.00$, $p = .026$.

*$p < .05$.

A final review of all demographic variables was completed in an effort to locate further possible relationships in the data set. The relationship between years worked and personal need for structure was examined but there were no significant differences found in the coping responses utilized by respondents with a varying number of years employed in the facility. Correlations were also examined between type of coping style and the years of experience. No significant relationships were found. Additionally, the researcher examined the correlation between the perception of threat and danger type of coping response. Once again, no significant relations were found.

Table 14 summarizes the primary hypothesized findings, and Table 15 summarizes the findings related to the secondary analyses of the data set.

TABLE 14

SUMMARY OF FINDINGS RELATED TO THE PRIMARY ANALYSIS OF THE DATA SET

Hypotheses	Outcome	Evidence
1. There is no relationship between personal need for structure and perceived predictability.	Rejected	Personal need for structure was positively correlated with perceived predictability
2. There is no relationship between personal need for structure and perceived stress.	Did Not Reject	Personal need for structure was not significantly correlated with perceived stress.
3. There is no relationship between personal need for structure and perceived social support.	Did Not Reject	Personal need for structure was not significantly correlated with perceived social support.
4. There is no relationship between personal need for structure and task-oriented coping.	Rejected	Personal need for structure was positively correlated with task-oriented coping.
5. There is no relationship between personal need for structure and avoidance-oriented coping.	Did Not Reject	Personal need for structure was not significantly correlated with avoidance-oriented coping.
6. There is no relationship between personal need for structure and emotion-oriented coping.	Did Not Reject	Personal need for structure was not significantly correlated with emotion-oriented coping.
7. There are no clear predictors of task-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support).	Rejected	Personal need for structure and perceived predictability were the best predictors of task-oriented coping.
8. There are no clear predictors of avoidance-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support).	Rejected	Perceived social support was the only significant predictor of avoidance oriented coping.
9. There are no clear predictors of emotion-oriented coping responses (in relation to personal need for structure, perceived predictability, perceived stress, and perceived social support).	Rejected	Perceived stress and perceived social support were the best predictors of emotion-oriented coping.

TABLE 15

SUMMARY OF FINDINGS RELATED TO THE SECONDARY ANALYSIS OF THE DATA SET

Nurses perception of social support greater than mental health aides.
Nurses use task and avoidance-oriented coping responses more than mental health aides.
For mental health aides and personal need for structure and task-oriented are correlated, perceived predictability and task-oriented coping are correlated.
For nurses, personal need for structure and task-oriented are correlated, perceived stress and emotion-oriented coping are correlated.
There were no predictors of avoidance-oriented coping.
Social support and perceived stress were the best predictors of emotion-oriented coping for mental health aides; only perceived stress was predictor for nurses.
Personal need for structure and perceived predictability were the best predictors of emotion-oriented coping for mental health aide, personal need for structure was the only predictor for nurses.

CHAPTER V

DISCUSSION

Introduction

Forensic psychiatric workers provide a valuable service to patients confined in forensic facilities. This study sought to examine what role the personality characteristic referred to as personal need for structure played in predicting coping style preference in this population.

Five of the original nine null hypotheses were rejected. Personal need for structure was found to be positively correlated with perceived predictability and task-oriented coping. The best predictors for task-oriented coping responses were found to be personal need for structure and perceived predictability. Perceived social support was the only significant predictor found to be related to avoidance-oriented coping. Perceived stress and perceived social support were found to be the best predictors of an emotion-oriented coping preference.

Some significant differences were found in the responses between nurses and mental health aides. Nurses had a greater perception of social support and used task- and avoidance-oriented coping responses more than the mental health aides. For both the nurses and the aides, personal

need for structure and task-oriented coping were found to be positively correlated. Perceived stress and emotion-oriented coping were also found to be correlated. For mental health aides, there was also a significant relationship focused between perceived predictability and a task-oriented coping preference.

A possible explanation related to why these differential results were attained may be found in the literature where a focus is given to gender differences. As stated in Chapter 2, Moos and Schaefer(1993) documented gender differences in coping styles. They reported that women have a tendency to use avoidance coping processes more frequently than men. Since the average mental health aid was an African American male, and the average nurse was an Asian American female, gender may have played a role in the observed differences found in the study at hand. Racial identity may have also played some role, and describes future research attention.

Respondents also indicated that although they do not feel particularly safe at work, or that the administration provides much support for their effort, they tended to like their jobs. This finding indicates that there exists some sort of a buffering effect which may influence individual job satisfaction and the overall stress experience.

Generalizations

It is recognized that the data set presented in this research project is from a small sub-population of mental health care workers. Considerable caution should be used when generalizing these results to other groups and/or settings. It would be faulty to assume that personal need for structure can universally predict coping preference. Research continuing the exploration is needed to delineate, more specifically, how personal need for structure influences a selection of a coping response.

Limitations

The limitations of this study result primarily from the sample size and peculiar characteristics of the sample. As voluntary respondents, a larger sample of forensic psychiatric workers was desired. However, at the time of the data collection, a larger group was unavailable. Size constraints of the sample may have had an unforeseen impact on the data, as noted in the differences focused between the mental health aides' and nurses responses. With this in mind, a special effort was made to increase the accuracy and the number of responses. In offering a ten dollar participation fee, an increased response rate was expected. The ten dollar participation fee probably assisted in gaining a larger response rate, but it is unclear as to how the use of the very modest subject participation payment may have impacted the study results.

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Another limitation to the study was the fact that, although every worker was approached to participate during their shift, very few of the late shift workers chose to participate in the study. Receipt of their responses may have added further to the understanding of experience of the forensic psychiatric worker. It is unclear as to how the non-respondents may have biased the overall results of the study. This added information may have assisted in clarifying differences between the nurses and the mental health aides.

There is always the possibility that since these respondents are from the New York City area, that there is some special and unknown effect related to their regional living area. One could argue that New Yorker's are a bit more tough skinned and this may have some effect on their responses. A way to systematically address this issue would be to use a representative national sample.

Of the measures utilized in this study, two of the specially constructed scales were not found to be very reliable (perceived stress, .52; and, perceived social support, .54). Further work needs to be done to refine these scales and enhance their reliability. There were also three demographic items that several respondents appeared to misunderstand. When asked about "Number of years working with this population," some respondents may have combined

"Years at Kirby" resulting in an over-inflated estimate of years working with forensic psychiatric patients. Many respondents also reported a number of years after high school (i.e., 4, 5, 6) instead of total number of "Years of Education" (i.e., 16, 17, 18). Some clarification seems to be needed to improve the strength of these problematic items.

Implications

There are both theoretical and practical implications to consider here. The theoretical implications impact the study of coping response. From what is reported above, task-oriented coping appears to be related to personal need for structure as well as their individual perceptions. The implication with respect to the individual difference literature is that another construct (personal need for structure) with which variation on stress adaptation and/or behavior may be assessed.

In examining the stress experiences and coping responses of forensic psychiatric workers, a greater understanding of their experiences may be attained. The stress experienced by forensic psychiatric workers may interest several groups. These groups include forensic psychiatric workers, facility administrators, work labor unions, recruitment personnel, and employee assistance programs. By identifying effective coping strategies, staff

training and orientation programs may be systematically developed to assist in addressing stress related issues. Identifying those in need of stress reduction workshops and/or training, and offering appropriate interventions may, at very least, address issues effecting job performance and patient care. Once facility administrators interested in addressing these issues recognize the role of stress in the workplace, avenues through which it can be addressed can be organized. If appropriate, it may be possible to offer individuals employed within the forensic facility effective stress reduction assistance to deal with the job.

This information may not only aid in the assessment and recruitment of workers, but it can provide information which can determine which individual characteristics are better suited for performing these tasks. As suggested by Thompson, et al. (1993) and Moskowitz (1993), individuals with personal need for structure perform better in jobs where their need for structure would be an asset and difficulty with ambiguity is not problematic. It is premature to suggest that the use of a scale which focuses on personal need for structure can contribute significantly to the selection process of forensic psychiatric workers; further research and refinement is needed to assess the true usefulness of the scale.

Future Research

It is recommended that future researchers should seek to increase the sample size by compiling data from various forensic psychiatric facilities on a national level and accounting for between group differences. Research should be designed to focus on the assessment of personal need for structure during a stressful transaction in an effort to explore whether or not there continues to be a positive relationship in task-oriented coping. This type of study would allow us to address the issue of dispositional versus situational factors and/or reactions to stress. In exploring the possible differences between the reactions to stress, much more can be understood related to the nature of stress in the workplace.

Another possible research area related to a personal need for structure and coping responses would be to assess the coping responses of the medically ill. Treatment outcome studies which examine the coping response, and personal need for structure could be of special interest here. This type of study could describe to what degree an individual with personal need for structure effectively uses task-oriented coping when responding to the stress associated with a serious medical illness. A fine-grained qualitative methodology research could also be used to determine the relationship between individual personality characteristics and stress reactions.. This type of study

could further assist us to understand how future workers (in high stress environs) cope with job demands.

Conclusions

The overall goal of this research project was to contribute to the understanding of the personal need for structure construct by systematically examining it's interplay with coping response preference. The results revealed several significant relationships between coping responses and personal need for structure. The most important of which is that there exists a relationship between personal need for structure and task-oriented, avoidance- and emotion-oriented coping responses.

It is concluded therefore, that personal need for structure is directly related to task-oriented coping preference. It appears that persons with high need for personal structure tend to use task-oriented coping responses more than do those with lower needs for personal structure. They (i.e., those with high personal need for structure) also reported less stress and greater levels of social support in their lives than did those lower in need for personal structure. Together, these findings suggest that personal need for structure may be a personality variable that serves as an important stress buffer for those employed in high stressful environments. The robustness of these findings of this study need replication in the future.

The implications (i.e., the health protecting, stress buffering effects of personal need for structure) also deserves further research attention. In offering attention to those who work in the forensic psychiatric field, one can hope to improve not only the worker's experiences, but patient care and treatment as well.

APPENDIX

APPENDIX A

LETTER OF APPROVAL FROM LOYOLA UNIVERSITY CHICAGO'S INSTITUTIONAL REVIEW BOARD

INSTITUTIONAL REVIEW BOARD
RESEARCH SERVICES OFFICE
LOYOLA UNIVERSITY OF CHICAGO
6525 NORTH SHERIDAN ROAD
CHICAGO IL 60626

Tel: (312) 508-2471 Matthew Creighton, SJ, Chair

August 4, 1994

Investigator: Nilsa Rivera
Home Address:

Home Telephone: de: 718]

| Please check the above information for accuracy and call in any corrections to 508-2471 |

Dear Colleague,

Thank you for submitting the following research project for review by the Institutional Review Board for the Protection of Human Subjects:

Project Title: Work Stress in the Forensic Psychiatric Facility: The Relationship Between Coping Responses and Personal Needs.....

After careful examination of the materials you submitted, we have approved this project as described for a period of one year from the date of this letter.

Approximately eleven months from today, you will receive from the IRB a letter which will ask whether you wish to apply for renewal of IRB approval of your project. You will be asked whether there have been any changes in the nature of the involvement of human subjects in your project since it was first approved, and whether you foresee any such changes in the near future. If your responses to these questions are timely and sufficiently explicit, the IRB will at that time renew your approval for a further twelve-month period. If you do not return that form by August 4, 1995, however, your approval will automatically lapse.

This review procedure, administered by the IRB itself,

in no way absolves you personally from your obligation to inform the IRB in writing immediately if you propose to make any changes in aspects of your work that involve the participation of human subjects. The sole exception to this requirement is in the case of a decision not to pursue the project--that is, not to use the research instruments, procedures or populations originally approved. Researchers are respectfully reminded that the University's willingness to support or to defend its employees in legal cases that may arise from their use of human subjects is dependent upon those employees' conformity with University policies regarding IRB approval for their work.

Should you have any questions regarding this letter or the procedures of the IRB in general, I invite you to contact me at the address or the telephone number shown on the letterhead. If your question has directly to do with the project we have just approved for you, please quote file number 1230.

With best wishes for your work,

Sincerely,

Matthew Creighton (mj)

Matthew Creighton, SJ

APPENDIX B

LETTER OF APPROVAL FROM KIRBY FORENSIC PSYCHIATRIC CENTER

Kirby
Forensic
Psychiatric Center

WARD'S ISLAND, NEW YORK 10035 (212) 427-9003

Renate C. Wack, Dipl. Psych., MPH
Executive Director

Stuart M. Linder, MBA
Director, Administrative Services

Kin Wah Lee, RRA, MPS
Director, Quality Assurance

Gloria Martin, RNC, MPA
Director, Nursing Services

New York State Office of Mental Health

Richard C. Surles, Ph.D., Commissioner
Joel A. Dvoskin, Ph.D., Associate Commissioner, Forensic Services

July 21, 1994

Nilsa Rivera, M.S.

RE: Dissertation Proposal

Dear Ms. Rivera;

After careful consideration of your dissertation proposal, the Institutional Review Board of Kirby Forensic Psychiatric Center approves your study. It is understood that you will collect survey materials from the nurses and SHTA's at Kirby before and after their shifts. It is also understood that the participants will sign a notice of informed consent and receive $10 for their voluntary and confidential responses.

Should you need to contact me regarding your research while at Kirby, please do not hesitate to contact me at 212-427-9003 extension 3560. Good luck with you dissertation research.

Sincerely,

Stuart Kirschner, Ph.D.
Forensic Program Administrator
Kirby Forensic Psychiatric Center

c.c. File
Renata Wack, Ph.D., ABPP, MPH
Joel Dvoskin, Ph.D.

APPENDIX C

LETTER OF SUPPORT FROM NEW YORK STATE OFFICE OF MENTAL HEALTH DEPARTMENT OF FORENSIC SERVICES

NEW YORK STATE
OFFICE OF MENTAL HEALTH

44 Holland Avenue, Albany, New York 12229
TDD No.—(518) 473-2714

RICHARD C. SURLES, Ph.D., Commissioner

BRUCE E. FEIG
Executive Deputy Commissioner

August 25, 1994

Nilsa Rivera, M.S.

Dear Ms. Rivera:

Thank you for your letter of August 24, and congratulations on gaining I.R.B. approval of your research project. As we discussed, I am very supportive of the proposal, and wish you the best of luck in its successful completion. Please let me know if I can be of any assistance.

Sincerely,

Joel A. Dvoskin, Ph.D.
Associate Commissioner for
Forensic Services

cc: R. Wack, Ph.D.

APPENDIX D

PERMISSION TO USE THE PERSONAL NEED FOR STRUCTURE SCALE

July 25, 1994

Ms. Nilsa Rivera

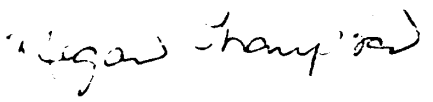
Dear Ms. Rivera:

I, along with Michael E. Naccarato and Kevin H. Parker, hold the copyright to The Personal Need for Structure Scale, which is presented in the appendix of a manuscript entitled *Assessing Cognitive Needs: The Development and Validation of the Personal Need for Structure and Personal Fear of Invalidity Scales,* University of Waterloo, Waterloo, Ontario, Canada.

I hereby grant you permission to use the Personal Need for Structure Scale (PNS) in your dissertation research, and to reprint the PNS scale in an appendix of your dissertation.

Best of luck with your dissertation research, Nilsa. Please do not hesitate to contact me if I can be of further help.

Sincerely,



Megan M. Thompson, Ph.D.
Department of Human Factors
Defence and Civil Institute of
Environmental Medicine
1133 Sheppard Ave. W,
P. O. Box 2000
North York Ontario, Canada
M3M 3B9
Phone: 416-635-2040
FAX: 416-635-2104

APPENDIX E

PERMISSION TO USE THE SIX ITEMS FROM THE COPING INVENTORY FOR STRESSFUL SITUATIONS

MHS
Helping You To Help Others

Multi-Health Systems Inc.
Publishers of Professional and Practice Materials

November 6, 1995

Nilsa Rivera

Dear Ms. Rivera:

Thank you for your interest in **The Coping Inventory for Stressful Situations (CISS)** by Drs. Endler and Parker.

MHS grants you permission to reproduce *up to six items* from the CISS in the appendix of your dissertation. Permission is contingent on your acknowledgment of the items as copyrighted by MHS. The items should be referenced as, "© 1990 Multi-Health Systems Inc., 908 Niagara Falls Boulevard, North Tonawanda, NY, 14120-2060, (800) 456-3003. Reproduced by permission". MHS further extends this authorization to University Microfilms International for the purpose of reproducing and distributing microfilmed copies of the dissertation. This grant of permission is nonexclusive and is not to be construed as granting any rights other than that described.

I trust that this is satisfactory. Should you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Joanne Morrison
Permissions Officer

In Canada
65 Overlea Blvd., Suite 210
Toronto, Ontario M4H 1P1

In the United States
908 Niagara Falls Blvd.,
North Tonawanda, NY 14120-2060

Phone: (416) 424-1700

Fax: (416) 424-1736

APPENDIX F

FLYER POSTED TO GIVE NOTICE OF DATA COLLECTION

ATTENTION ALL KIRBY

SHTAs AND NURSEs

I need your help!! I am Nilsa Rivera, one of the psychology interns from this past year and I need to ask for your help with my dissertation research.

As some of you know, I am interested in researching Stress in the Forensic Psychiatric Facility. Your experience while working with these forensic psychiatric patients is important to me, and I would like you to answer a brief questionnaire about stress. All you need to do is answer some questions and I will pay you **$10** for 15 minutes worth of your time. I will hand out the questionnaires before your shift and pick them up after your shift.

This is a completely **anonymous, confidential and voluntary** study. I am the only one that will ever have access to the data and no one at Kirby will ever know how you answered. After the data has been analyzed you can get feedback about the overall research outcome from me directly.

I will be handing out my research questionnaire from **Wednesday (12/7) thru Saturday (12/23)** and I will answer any questions that you may have about the study. I hope you decide to participate.

Thanks,

Nilsa Rivera
12/2/94

APPENDIX G

NOTICE OF INFORMED CONSENT

Dear Kirby Staff Member:

Hi, my name is NILSA RIVERA, and was a Psychology Intern at Kirby (4E & 3W) last September. I am currently working on my dissertation and I have decided to research the stress experiences of SHTA's and Nurses at Kirby. Since I have had an opportunity to work closely with some of your colleagues on different units I have learned that each individual member of the treatment team makes a valuable contribution in the care and management of the forensic psychiatric patient. I am contacting you directly to ask for your help. In the short time that I worked at Kirby, I've noticed that stress is a part of the everyday work experience of the front-line, patient care staff. Since we all react to stress differently, it is important to know how to handle the stress of working with this difficult patient population. Your knowledge and experiences of working with this difficult population makes you uniquely qualified to offer feedback on stress. How you deal with the stress that working with this population can create is the focus of my dissertation research. It cannot be completed without your help.

Both my dissertation committee and KFPC have agreed that research which focuses on your work with patients is important, and they have allowed me to approach you for your experiences. Understanding how you react to stress may help others understand the uniqueness of forensic psychiatric patient work. Please take the time to answer these questions. As patient care experts, I would really appreciate your feedback on the research that I am doing. Since this is my own dissertation work and your participation is needed, I will pay you **$10** (cash) for your time.

Notice of Informed Consent

There are some questions on each sheet about the way you react to stress and what you are like. It should take less than 15-minutes to answer all the questions. **All of the responses on the survey are anonymous and confidential, please do not write your name anywhere on the survey.** Your participation is completely voluntary and the foreseeable risk is extremely low. The only foreseeable risk is a slight discomfort you may feel by answering the questions regarding stress in your life. If you decide that you would like further information about handling stress in your life, the EAP person to contact is Ms Mary Clarke (3630 or 3622) she can refer you to someone that can help you.

Since this is my dissertation research, the **KFPC administration will never see any part of my data**, I am the only one who will use this information. Immediately after the data have been analyzed all surveys will be destroyed. If after you answer these questions, you feel like you would prefer not to participate, you can call me to indicate that you no longer want to participate and your answers will be deleted from the study before the data analyses. You have one-week from this date to withdraw your responses. After the study is complete I will return with feedback about the results. Please sign both copies of this letter in the space provided below and give the top sheet to me, *the second sheet is a duplicate for your records.* Your signature on this form will indicate that you have considered all of the information above and have decided to participate. Thank you again for your assistance.

Sincerely yours,

Nilsa Rivera, M.S. Date Participant's signature

APPENDIX H

STATEMENT MADE TO PARTICIPANTS

Hi, my name is NILSA RIVERA, and I was a Psychology Intern on 3 West. I'm currently working on my dissertation. I put up notices about my research recently. I left Kirby in September after I finished my internship. I have had an opportunity to work closely with some of your colleagues on different units. Working here has taught me that each individual member of the treatment team makes a valuable contribution in the care and management of these patients. I am coming to you directly to ask for your help with my dissertation research. The stress that working with this population can create is the focus of my dissertation research. As people who work with these patients closely, I would really appreciate your feed back on some questions. In the short time that I worked here, I noticed that stress was a part of the everyday work experience of the front-line, patient care staff. Since we all react to stress differently, it is important to know how you handle the stress, and how it can be alleviated or at least addressed. Your knowledge and experiences of working with this population, considered dangerous, makes you uniquely qualified to offer feedback on stress.

The survey that I am giving you is only four pages and you just need to indicate the answers that best describe your thoughts or feelings. There are no right or wrong

answers and no one but me will ever know what the responses were. I had to get several approvals before I approached you and no one else will have access to my data. My dissertation committee and Kirby agree that it's a unique project. After you answer the questions, put the survey into this brown envelope. I will go around collecting the envelopes for the next two weeks. I really need your help and I'll pay each person $10 for their time. I know that there's not enough time for you to do them right now, but I will be going on all the units on different shifts to pick up completed surveys.

The consent letters that are around the envelopes are to serve as your notice of the research and what it entails. The 2 copies of the letter list my work number where I can be reached to further discuss this study. After you read the letter, please sign both forms. Return the top form to me with the survey. Keep the bottom form for your records. When you return the letter and the survey to me completed I'll give you the ten dollars.

Remember that stress is a normal part of everyday life and if you'd like to address the way stress effects you, the Employee Assistance Program (Ms. Mary Clarke @3860) is available for help.

Since this is my dissertation, I am the only one who is responsible for all of the costs of the Xeroxing, envelopes,

data analysis and $10 payments. The reason I am putting so much time, money, and effort into this is because it is an important, understudied area and I believe it's a worth investigating. The responses are anonymous and confidential. No one at Kirby will have any access to the surveys. When my dissertation is complete, each survey will be destroyed.

The surveys are right here. I hope you decide to help me. Thanks.

APPENDIX I

SIX ITEMS PERMITTED TO BE REPRODUCED FROM THE COPING INVENTORY FOR STRESSFUL SITUATIONS

Six Items Permitted to be Reproduced From the Coping Inventory For Stressful Situations[6] (Endler & Parker, 1990)

Respondents were asked to indicate, on a scale from one to five, how much they engage in the following sample of behaviors when they "encounter a difficult, stressful, or upsetting situation."

Not at All				Very Much	
1	2	3	4	5	1. Schedule my time better.
1	2	3	4	5	14. Become very tense.
1	2	3	4	5	29. Visit a friend.
1	2	3	4	5	38. Get angry.
1	2	3	4	5	40. See a movie.
1	2	3	4	5	48. Watch TV.

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APPENDIX J

THE PERSONAL NEED FOR STRUCTURE SCALE

The Personal Need for Structure Scale[7]

Instructions

Read each of the following statements and decide how much you agree with each according to your attitudes, beliefs, and experiences. It is important for you to realize that there are no "right" or "wrong" answers to these questions. People are different, and we are interested in how you feel. Please respond according to the following 6-point scale:

1 = strongly disagree	4 = slightly agree
2 = moderately disagree	5 = moderately agree
3 = slightly disagree	6 = strongly agree

1. It upsets me to go into a situation without knowing what I can expect from it..... 1 2 3 4 5 6
2. I'm not bothered by things that interrupt my daily routine..... 1 2 3 4 5 6
3. I enjoy having a clear and structured mode of life. 1 2 3 4 5 6
4. I like to have a place for everything and everything in its place..... 1 2 3 4 5 6
5. I enjoy being spontaneous. 1 2 3 4 5 6
6. I find that a well-ordered life with regular hours makes my life tedious..... 1 2 3 4 5 6
7. I don't like situations which are uncertain 1 2 3 4 5 6
8. I hate to change my plans at the last minute.. ..... 1 2 3 4 5 6
9. I hate to be with people who are unpredictable 1 2 3 4 5 6
10. I find that a consistent routine enables me to enjoy life more. 1 2 3 4 5 6
11. I enjoy the exhilaration of being in unpredictable situations..... 1 2 3 4 5 6
12. I become uncomfortable when the rules in a situation are not clear. 1 2 3 4 5 6

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[7]Note: From Assessing Cognitive Needs: The Development and the Validation of the Personal Need for Structure and Personal Fear of Invalidity Scales, by Thompson, Naccarato & Parker (1990), University of Waterloo, Waterloo, Ontario Canada. Used and reprinted by permission.

APPENDIX K

THE WORK ENVIRONMENT FORM

Work Environment Form

STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE	Indicate how much you AGREE with the following statements. The term social network refers to people with whom you are most closely involved (i.e., your family, spouse, friends, church/social club members, etc.). CIRCLE THE NUMBER FROM 1 TO 5.
1	2	3	4	5	1. My job can be stressful at times.
1	2	3	4	5	2. My social network supports my work at Kirby.
1	2	3	4	5	3. I can talk to my social network about my stressful experiences with patients.
1	2	3	4	5	4. My social network is reliable.
1	2	3	4	5	5. My social network really understands what my job is about.
1	2	3	4	5	6. My social network support is adequate.
1	2	3	4	5	7. There are times when the ward feels really out of control.
1	2	3	4	5	8. More often than not, I can tell when a patient will 'go off.'
1	2	3	4	5	9. There should be more structure on the unit to prevent assaults.
1	2	3	4	5	10. I have support from my social network, they are always around.
1	2	3	4	5	11. Generally, things don't change for the better around here.
1	2	3	4	5	12. I receive guidance from my social network.
1	2	3	4	5	13. Working with the staff at Kirby is stressful.
1	2	3	4	5	14. When one patient is 'taken down,' I fear others may 'go off' too.
1	2	3	4	5	15. I fear being assaulted by a patient.
1	2	3	4	5	16. Once I get to know a patient's behavior, I'm more comfortable.
1	2	3	4	5	17. The noise level on the ward causes me stress.
1	2	3	4	5	18. I feel confident in my ability to handle an emergency at work.
1	2	3	4	5	19. I have a difficult working relationship with my supervisor.
1	2	3	4	5	20. My life is pretty good right now.
1	2	3	4	5	21. I like to know what tasks I'll be doing throughout the day.
1	2	3	4	5	22. I feel comfortable when I can predict a patient's behavior.
1	2	3	4	5	23. The union has been helpful in negotiating with management.
1	2	3	4	5	24. I can discuss the stress I'm experiencing with those who place demands on me.
1	2	3	4	5	25. My supervisor is supportive of me.
1	2	3	4	5	26. Support from my social network is important.
1	2	3	4	5	27. Patients are likely to claim abuse if they are angry with you.
1	2	3	4	5	28. Supervisors take the patients' side more than the staff's side.
1	2	3	4	5	29. I have to do more work because others aren't doing their share.
1	2	3	4	5	30. There are too many patients and not enough staff.
1	2	3	4	5	31 I'm pretty good at predicting when a patient will 'go off.'
1	2	3	4	5	32. Staff safety is considered when new policies are made.
1	2	3	4	5	33. My financial situation is worrisome.
1	2	3	4	5	34. I let my social network know when I'm upset.
1	2	3	4	5	35. Changes in work assignments influence my level of stress.
1	2	3	4	5	36. S.H.T.A.'s are treated like 'second class citizens.'

1	2	3	4	5	37. When a patient goes off, I automatically know what to do.
1	2	3	4	5	38. Support from the people I work with is important to me.
1	2	3	4	5	39. I don't like my job.
1	2	3	4	5	40. Someone close to me has recently become ill or passed away.
1	2	3	4	5	41. This is a very stressful place to work.
1	2	3	4	5	42. My home life is somewhat unpredictable.
1	2	3	4	5	43. Younger patients cause me more stress than older patients.
1	2	3	4	5	44. If a patient ever hit me, I would file assault charges against them.
1	2	3	4	5	45. The administration is not fair when investigating abuse.
1	2	3	4	5	46. Even if I am falsely accused of abuse, my job is in jeopardy.
1	2	3	4	5	47. I handle the pressures of working here pretty well.
1	2	3	4	5	48. I am currently experiencing stress in my home life.
1	2	3	4	5	49. Supervisors encourage me towards self-improvement.
1	2	3	4	5	50. The higher the risk of patient escape or violence, the more I worry.
1	2	3	4	5	51. My social network is readily accessible.
1	2	3	4	5	52. I am concerned about the personal problems or difficulties my social network is experiencing.
1	2	3	4	5	53. I feel safe at work.
1	2	3	4	5	54. I'm generally quick to respond to a patient incident.
1	2	3	4	5	55. I have no significant problems that cause me stress.
1	2	3	4	5	56. I am generally healthy, no headaches or stomach problems.
1	2	3	4	5	57. When I have free time, I spend it with my social network.
1	2	3	4	5	58. My relationship with the administration is supportive.
1	2	3	4	5	59. I enjoy being with my social network.
1	2	3	4	5	60. I experience stress on a regular basis.

How many times a week do you go out with close friends? 0 1 2 3 4 5/more	Title: S.H.T.A. Nurse Shift: Day Eves Nights Education: ____yrs	Number of years that you have worked with this type of patient (not at Kirby)? __	How long have you worked at Kirby? ___yr___mo Do you plan to retire from here? Yes No
In an average work week, how many patient "incidence(s)" do you experience? 0 1 2 3 4 5/more	Working overtime today? Yes No Average overtime hours worked per week? ____	Are these patients likely to assault you? Yes No	During what time of the day (or activity) do you feel at highest risk for being hurt by a patient? _____
Race (optional): African American Asian American Hispanic American Caucasian Other	**Age (optional):** ___ **Gender: (optional)** **Male** Female	**Marital Status (optional):** Single Married Divorced	Comments? Write on back

APPENDIX L

DESCRIPTION OF INDEPENDENT AND DEPENDENT VARIABLE SCALES

Personal Need for Structure (PNS)

↓ Scale r	↓ Item Number	↓ Actual Item
.73	PNS07	I don't like situations which are uncertain.
.65	PNS01	It upsets me to go into a situation without knowing what I can expect.
.62	PNS09	I hate to be with people who are unpredictable.
.62	PNS08	I hate to change my plans at the last minute.
.61	PNS03	I enjoy having a clear and structured mode of life.
.60	PNS10	I find that I consistent routine enables me to enjoy life more.
.52	PNS04	I like to have a palace for everything and everything in its place.
.55	PNS12	I become uncomfortable when the rules in a situation are not clear.
.37	PNS02	I'm not bothered by things that interrupt my daily routine.
.32	PNS06	I find that a well-ordered life with regular hours makes my life tedious.
-.16	PNS11	I enjoy the exhilaration of being in unpredictable situations.

Coping Inventory For Stressful Situations (CISS)†

↓ Scale	r	↓ Item	↓ Scale	r	↓ Item	↓ Scale	r	↓ Item
T	.29	CISS01	A	.65	CISS18	A	.44	CISS35
T	.54	CISS02	E	.56	CISS19	T	.52	CISS36
A	.51	CISS03	A	.62	CISS20	A	.64	CISS37
A	.49	CISS04	T	.68	CISS21	E	.43	CISS38
E	.49	CISS05	E	.63	CISS22	T	.64	CISS39
T	.57	CISS06	A	.46	CISS23	A	.76	CISS40
E	.57	CISS07	T	.65	CISS24	T	.75	CISS41
E	.54	CISS08	E	.49	CISS25	T	.73	CISS42
A	.48	CISS09	T	.70	CISS26	T	.60	CISS43
T	.53	CISS10	T	.73	CISS27	A	.47	CISS44
A	.39	CISS11	E	.51	CISS28	E	.33	CISS45
A	.65	CISS12	A	.67	CISS29	T	.28	CISS46
E	.61	CISS13	E	.65	CISS30	T	.65	CISS47
E	.64	CISS14	A	.66	CISS31	A	.56	CISS48
E	.58	CISS15	A	.38	CISS32			
E	.45	CISS16	E	.44	CISS33			
E	.66	CISS17	E	.74	CISS34			

Note. A = Avoidance-Oriented Coping scale item; T = Task-Oriented Coping scale item; E = Emotion-Oriented Coping scale item.

†Items were unable to be reproduced due to copyrighting.

Work Environment Form (WEF)

↓ Scale	r	↓ Item Number	↓ Actual Item
PS	.22	WEF01	My job can be stressful at times.
SS	.65	WEF02	My social network supports my work at Kirby.
SS	.66	WEF03	I can talk to my social network about stressful experiences with patients.
SS	.82	WEF04	My social network is reliable.
SS	.72	WEF05	My social network really understands what my job is about.
SS	.70	WEF06	My social network support is adequate.
PP	-.08	WEF07	There are times when the ward feels really out of control.
PP	.52	WEF08	More often then not, I can tell when a patient will 'go-off.'
PP	.38	WEF09	There should be more structure on the unit to prevent assaults.
SS	.76	WEF10	I have support from my social network, they are always around.
PS	.46	WEF11	Generally, things don't change for the better around here.
SS	.76	WEF12	I receive guidance from my social network.
PS	.55	WEF13	Working with the staff at Kirby is stressful.

PP	.54	WEF14	When one patient is 'taken-down,' I fear others may 'go-off' too.
PS	.44	WEF15	I fear being assaulted by a patient.
PP	.41	WEF16	Once I get to know a patient's behavior, I'm more comfortable.
PP	.60	WEF17	The noise level on the ward causes me stress.
PP	.39	WEF18	I feel confident in my ability to handle an emergency at work.
PS	.35	WEF19	I have a difficult working relationship with my supervisor.
PS	.44	WEF20	My life is pretty good right now.
PP	.47	WEF21	I like to know what tasks I'll be doing throughout the day.
PP	.58	WEF22	I feel comfortable when I can predict a patient's behavior.
SS	.32	WEF23	The union has been helpful in negotiating with management.
PS	-.16	WEF24	I can discuss the stress I'm experiencing with those who place demands on me.
PS	-.09	WEF25	My supervisor is supportive of me.
SS	.58	WEF26	Support from my social network is important.
SS	-.31	WEF27	Patients are likely to claim abuse if they are angry with you.
SS	.26	WEF28	Supervisors take the patients' side more than the staff's side.

PS	.58	WEF29	I have to do more work because others aren't doing their share.
PS	.58	WEF30	There are too many patient's and not enough staff.
PP	.62	WEF31	I'm pretty good at predicting when a patient will 'go-off.'
SS	.31	WEF32	Staff safety is considered when new policies are made.
PS	.40	WEF33	My financial situation is worrisome.
SS	.68	WEF34	I let my social network know when I'm upset.
PS	.54	WEF35	Changes in work assignments influence my level of stress.
SS	.41	WEF36	S.H.T.A.'s are treated like 'second-class citizens.'
PP	.45	WEF37	When a patient goes off, I automatically know what to do.
SS	.16	WEF38	Support from the people I work with is important to me.
PS	.56	WEF39	I don't like my job.
PS	.24	WEF40	Someone close to me has been recently become ill and passed away.
PS	.51	WEF41	This is a very stressful place to work.
PS	-.27	WEF42	My home life is somewhat unpredictable.
PP	.50	WEF43	Younger patients cause me more stress than older patients
PP	.40	WEF44	If a patient ever hit me, I would file assault charges against them.

SS	.36	WEF45	The administration is not fair when investigating abuse.
SS	.31	WEF46	Even if I am falsely accused of abuse my job is in jeopardy.
PS	-.16	WEF47	I handle the pressures of working here pretty well.
PS	.60	WEF48	I am currently experiencing stress in my home life.
SS	.17	WEF49	Supervisors encourage me towards self-improvement.
PS	.46	WEF50	The higher the risk of patient escape or violence, the more I worry.
SS	.70	WEF51	My social network is readily accessible.
SS	.42	WEF52	I am concerned about the personal problems or difficulties my social network is experiencing.
PS	.55	WEF53	I feel safe at work.
PP	.47	WEF54	I am generally quick to respond to a patient incident.
PS	.48	WEF55	I have no significant problems that cause me stress.
PS	.34	WEF56	I am generally healthy, no headaches or stomach problems.
SS	.59	WEF57	When I have free time I spend it with my social network.
SS	.47	WEF58	My relationship with the administration is supportive.
SS	.55	WEF59	I enjoy being with my social network.
PS	.61	WEF60	I experience stress on a regular basis.

Note. WEF = Work Environment Form
A = Avoidance-oriented coping
T = Task-oriented coping
SS = Perceived Social Support
E = Emotion-oriented coping
PS = Perceived Stress
PP = Perceived Predictability

REFERENCES

Aldwin, C.M. & Revenson, T.A. (1987). Does coping help? A re-examination of the relation between coping and mental health. Journal of Personality and Social Psychology, 53, 337-348.

Amirkhan, J.H. (1990). A factor analytically arrived measure of coping: The Coping Strategy Indicator. Journal of Personality and Social Psychology, 59, 1066-1074.

Billing, A.G. & Moos, R.H. (1984). Coping, stress and social resources among adults with unipolar depression. Journal of Personality and Social Psychology, 46, 877-891.

Bond, M., Gardner, S.T., Christian, J. & Sigel, J. (1983). Empirical Study of self-rated defense styles. Archives of General Psychiatry, 40, 333-338.

Breen, L. (1984). The Forgotten Keepers: Stress and the Correctional Employees. Unpublished Manuscript.

Brodsky, C.M. (1982). Work stress in correctional institutions. Journal of Prison and Jail Health, 2, 74-102.

Burger, J.M. (1992). Desire For Control: Personality, Social and Clinical Perspectives. New York: Plenum Press.

Burke, R.J. (1993). Work-Family stress, conflict coping and burnout in police officers. Stress Medicine, 9(3), 171-180.

Carver, C.S., Scheier, M.F., & Weintraub, J.K. (1989). Assessing coping strategies: A theoretically based approach. Journal of Personality and Social Psychology, 56(2), 267-283.

Carver, C.S., & Scheier, M.F. (1994). Situational coping and coping disposition in a stressful transaction. Journal of Personality and Social Psychology, 66(1), 184-195.

Ceslowitz, S.B. (1989). Burnout and coping strategies among hospital staff nurses. Journal of Advanced Nursing, 14(7), 553-558.

Cheek, F.E. & Miller, M.D. (1981). Stress and Burnout In Maximum, Medium, and Minimum Correctional Facilities in Three States: Pennsylvania, Illinois and Washington. Unpublished manuscript.

Cheek, F.E. & Miller, M.D. (1982a). Prisoners of Life: A Study of Occupational Stress Correctional Officers. Washington, DC: AFSCME.

Cheek, F.E. & Miller, M.D. (1982b). Reducing staff and inmate stress. Corrections Today, 72-78.

Cheek, F.E. & Miller, M.D. (1983). The experience of stress for correctional officers: A double bind theory of

correctional stress. Journal of Criminal Justice, 11, 105-120.

Colegrove, S.B. (1983). Personality and demographic characteristics as predictors of burnout in female police officers. Dissertation Abstracts International, 44(4-B), 1232-1233.

Corrigan, P.W. (1993). Staff stressors at developmental center and state hospital. Mental Retardation, 31(4), 234-238.

Derogatis, L. (1993). Self-report measures of stress. In L. Goldberger & S. Breznitz (Eds.) Handbook of Stress: Theoretical and Clinical Aspects (2nd ed.). New York: The Free Press.

Egan, M. (1993). Resilience at the front-lines: Hospital social work with AIDS patients and burnout. Social Work in Health Care, 18(2), 109-125.

Endler, N.S. & Parker, J.D.A. (1989). Coping with frustrations to self-realization: Stress, anxiety, crises and adjustment. In E. Krau (Ed.), Self-Realization, Success and Adjustment (pp. 153-164). New York: Praeger Publishers.

Endler, N.S. & Parker, J.D.A. (1990a). Coping Inventory For Stressful Situations (CISS): Manual. Toronto: Multi-Health Systems.

Endler, N.S. & Parker, J.D.A. (1990b). The multidimensional assessment of coping: A critical evaluation. Journal of Personality and Social Psychology, 58, 844-854.

Endler, N.S & Parker, J.D.A. (1990c). State and Trait anxiety, depression and coping styles. Australian Journal of Psychology, 42, 207-220.

Endler, N.S. & Parker, J.D.A. (1992). Toward a reliable and valid method for multidimensional assessment of coping with health problems. Paper presented at the annual meeting of the Canadian Psychological Association, Quebec City, Quebec, Canada, June.

Endler, N.S. & Parker, J.D.A. (1993a). The multidimensional assessment of coping: Concepts, issues and measurement. In C.L. VanHeck, P. Bonaiuto, I. Dreary, and W. Nowack (Eds.), Personality Psychology In Europe (Vol. 4). Tilburg, Netherlands: Tilburg University Press.

Endler, N.S. & Parker, J.D.A. (1993b). Assessing a patient's ability to cope. In J.M. Butcher (Ed.), Practical Considerations in Clinical Personality Assessment. New York: Oxford University Press.

Endler, N.S. & Parker, J.D.A. (In Press). Multidimensional assessment of coping: A critical evaluation. Journal of Personality and Social Psychology, 42, 207-220.

Endler, N.S. & Butcher, J.M. (1993). A factor analytic study of coping styles and the MMPI-2 content scales. Journal of Clinical Psychology, 49, 523-527.

Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? Special Issue: Sex Offender Treatment: Psychological and medical approaches. Journal of Offender Rehabilitation, 18(3-4), 217-223.

Fleischman, J.A. (1984). Personality characteristics and coping patterns. Journal of Health and Social Behavior, 25, 229-244.

Folkman, S. (1984). Personal control and stress and coping process: A theoretical analysis. Journal of Personality and Social Psychology, 46, 839-852.

Folkman, S. & Lazarus, R.S. (1985). If it changes it must be a process: A study of emotion and coping during three stages of college examination. Journal of Personality and Social Psychology, 48, 150-170.

Folkman, S. & Lazarus, R.S. (1988). Manual for the Ways of Coping Questionnaire. Palo Alto: Consulting Psychologist Press.

Folkman, S., Lazarus R.S., Pimley, S., & Novacek, J. (1987). Age differences in stress and coping processes. Psychology and Aging, 2, 171-184.

Freund, T., Kruglanski, A.W. & Schipitzajzen, A. (1985). The freezing and unfreezing of impressional

primacy: Effects of the need for structure and the fear of invalidity. Personality and Social Psychology Bulletin, 11(4), 479-487.

Graf, F.A. (1986). The relationship between social support and occupational stress among police officers. Journal of Police Science and Administration, 14(3), 176-186.

Gray, S. & Diers, D. (1992). The effect of staff stress on patient behavior. Archives of Psychiatric Nursing, 6(1), 26-34.

Haller, R.M. & Deluty, R.H. (1988). Assaults on staff by psychiatric inpatients: A critical review. British Journal of Psychiatry, 152, 174-179.

Hansen, P.A. (1981). Creative Stress Management for Law Enforcement and Correctional Officers. Longmont, CO.

Hodgins, S. (1992). Mental disorder, intellectual deficiency, and crime: Evidence from a birth cohort. Archives of General Psychiatry, 49, 476-486.

Holahan, C.J & Moos, R.H. (1987). Personal and contextual determinants of coping strategies. Journal of Personality and Social Psychology, 52(5), 946-955.

Jackson, D.N. (1989). Basic Personality Inventory Manual. Port Huron: Sigma Assessment Systems, Inc.

Kaplan, M.F., Wanshula, L.T. & Zanna, M.P. (1991). Time pressure and information integration in social

judgment: The effort of need for structure. In O. Svenson and J. Maule (Eds.), Time Pressure and Stress in Human Judgment and Decision Making. Cambridge, U.K.: Cambridge University Press.

Kaplan, M.L. (1987). The influence of stress environment, personality and coping on burnout among nurses. Dissertation Abstracts International, 48(2-B), 565.

Keller, K.L. (1990). The management of stress and prevention of burnout in emergency nurses. Journal of Emergency Nursing, 16(5), 313.

Kobasa, S.C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. Journal of Personality and Social Psychology, 37(1), 1-11.

Kruglanski, A.W. (1989). Lay Epistemics and Human Knowledge: Cognitive and Motivational Bases. New York: Plenum Press.

Kruglanski, A.W. & Freund, T. (1983). The freezing of lay inferences: Effects on impressional primacy, ethnic stereotyping, and numerical anchoring. Journal of Experimental Social Psychology, 19, 448-468.

Lazarus, R.S. (1966). Psychological Stress and the Coping Process. New York: McGraw Hill.

Lazarus, R.S. (1975). Psychological stress and coping in adaptation in illness. International Journal of Psychiatry and Medicine, 5, 321-33.

Lazarus, R.S. (1982). Thoughts on the relations between emotion and cognition. American Psychologist, 37, 1019-1024.

Lazarus, R.S. (1993). Coping theory and research: Past, present and future. Psychosomatic Medicine, 55, 234-247.

Lazarus, R.S. & Folkman, S. (1984). Stress Appraisal and Coping. New York: Springer.

Lazarus, R.S., Deese, J. & Osler, S.F. (1952). The effects of psychological stress upon performance. Psychological Bulletin, 49, 293-317.

Lazarus, R.S. & Folkman, S. (1987). Transactional theory and research on emotions and coping. European Journal of Personality, 1, 141-169.

Leiter, M.P. (1991). Coping patterns as predictors of burnout: The function of control and escapist coping patterns. Journal of Organizational Behavior, 12(2), 123-144.

Linaker, O.M. & Busch-Iversen, H. (1995) Predictors of imminent violence in psychiatric inpatients. ACTA Psychiatrica Scandinavica, 92(4), 250-254.

McCrae, R.R. (1989). Age differences and changes in the use of coping mechanisms. Journal of Gerontology, 44, 161-169.

Miller, S.M., Brody, D.S. & Summerton, S. (1988). Styles of coping with threat: Implications for health. Journal of Personality and Social Psychology, 54, 142-148.

Moos, R.H. & Schaefer, J.A. (1993). Coping resources and processes: Current concepts and measures. In L. Goldberger & S. Breznitz (Eds.), Handbook of Stress: Theoretical and Clinical Aspects (2nd ed., pp. 234-257). New York: The Free Press.

Moskowitz, G.B. (1993). Individual differences in social categorization: The influence of personal need for structure on spontaneous trait inferences. Journal of Personality and Social Psychology, 65(1), 132-142.

Naccarato, M.E. (1988). The impact of need for structure on stereotyping and discrimination. Unpublished master's thesis. University of Waterloo, Waterloo, Ontario, Canada.

Naisberg-Fennig, S., Fennig, S., Keinen, G. & Elizur, A. (1991). Personality characteristic and proneness to burnout: A study among psychiatrists. Stress Medicine, 7(4), 201-205.

Neale, A.V. (1991). Work stress in emergency medical technicians. Journal of Occupational Medicine, 33(9), 991-997.

Neuberg, S.L. & Newsom, J.T. (1993). Personal Need for Structure: Individual differences in the desire for

simple structure. Journal of Personality and Social Psychology, 65(1), 113-131.

Orman, M.C. (1989). Physician stress: Is it inevitable? Missouri Medicine, 86(1), 21-25.

Parker, J.D.A., Endler, N.S., & Bagby, R.M. (1993). If it changes, it might be unstable: Examining the factor structure of the Ways of Coping Questionnaire. Psychological Assessment, 5(3), 361-368.

Parker, J.D.A., & Endler, N.S. (1992). Coping with coping assessment: A critical review. European Journal of Personality, 6, 321-344.

Parkes, K.R. (1986). Coping in stressful episodes: The role of individual differences, environmental factors, and situation characteristic. Journal of Personality and Social Psychology, 51, 1277-1292.

Pearlin, L.I. & Schooler, C. (1978). The structure of coping. Journal of Health and Social Behavior, 19, 2-21.

Revicki, D.A. & May, H.J. (1989). Organizational characteristics, occupational stress, and mental health in nurses. Behavioral Medicine, 15(1), 30-36.

Rivera, N. (1994). The Work Environment Form. Unpublished instrument developed for this study.

Roman, R.J., Moskowitz, G.B., Stein, M.L., & Eisenberg, R.F. (1992). Individual differences in experiment participation: A consideration of subject

characteristics and the time of semester. Manuscript submitted for publication.

Schaefer, J. & Moos, R. (1991). Work stressors and coping among long term care staff. Palo Alto, CA: Center for Health Care Evaluations. Department of Veteran Affairs Medical Centers.

Schniedermayer, D.L. & Tesch, B.J. (1992). Primary care physician burnout: Definitions, self-assessments and treatment. Wisconsin Medical Journal, 91(4), 179-182.

Singh, R.G. (1990). Relationship between occupational stress and social support in flight nurses. Aviation and Environmental Medicine, 61(4), 349-352.

Sullivan, I.G. (1989). Burnout: A study of a psychiatric center. Loss, Grief & Care, 3(1-2), 83-93.

Thompson, M.M., Naccarato, N.E., Parker, J.D.A., & Moskowitz, G.B. (1993). Measuring Cognitive Needs: The Development and Validation of the Personal Need for Structure (PNS) and Personal Fear of Invalidity (PFI) Measures. Unpublished manuscript.

Thornton, P.I. (1992). The relation of coping appraisal and burnout in mental health workers. Journal of Psychology, 26(3), 261-71.

Wethington, E. & Kessler, R.C. (1986). Perceived support, received support and adjustment to stressful life

events. Journal of Health and Social Behavior, 27(1), 78-89.

Zautra, A.J., Reynolds, K.D. & Eblen, C. (1987). Some determinants of employee turnover in a psychiatric facility. Administration in Mental Health, 15(1), 11-17.

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The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Counseling Psychology.

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